WorkplaceNL

MAIL FORM TO:
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St. John's NL A1A 3B8
FAX FORM TO:
709.778.1302

CALL US AT:
telephone: 709.778.1000
toll-free: 1.800.563.9000
VISIT US AT:
workplacenl.ca

Please indicate applicable number	*Form*
CLAIM NUMBER (Worker)	**13**
FIRM NUMBER (Employer)	*Page 1 of 1 Rev. May 2016*

FORM 13 – Authorized Representative Form

This form must be completed by injured workers or employers who want another individual or company to be permitted access to WorkplaceNL information concerning their claim or employer files. It permits WorkplaceNL to share all information from your file as requested by your *Authorized Representative(s).* You can have more than one *Authorized Representative*. WorkplaceNL will not release any information to your representative unless this signed form is on your file. Once you declare an *Authorized Representative* you may change or remove that individual(s). In order to do this, you must complete another Form 13.

Your file is associated with an important number. For injured workers, it is your **Claim Number**, for employers, it is your **Firm Number**. Your *Authorized Representative(s)* is the only other individual who should know your personal number. For your protection, this number **MUST** be given to WorkplaceNL before any information is shared with you or your *Authorized Representative(s).*

For further information, please consult WorkplaceNL's Information Protection and Access Policy (GP-01) on our website: www.workplacenl.ca.

Authorization

Company Name (employer requests only) _____

I, _____ authorize ☐ remove ☐ *please check one*
please print name

Mr. or Ms. _____ of _____
please print name of authorized representative *organization name if applicable*

_____ _____
address *telephone*

to act as my *Authorized Representative*.

I understand that my *Authorized Representative(s)* may act on my behalf (or my company's behalf) until I indicate otherwise.

_____ _____
signature *date*