WorkplaceNL	P.O. Box 9000 146-148 Forest Road St. John's, NL A1A 3B8 ***VISIT:*** workplace.nl.ca	***CALL US AT:*** t 709.778.1000 t 1.800.563.9000 ***FAX FORM TO:*** f 709.778.1302	**Election To Claim Compensation (inter-jurisdictional)**

The *Workplace Health, Safety And Compensation Act of Newfoundland and Labrador*

WorkplaceNL Claim Number ______________________

Worker's Name ______________________ Date of Birth ______________________

Address ______________________ Social Insurance # ______________________

______________________ Telephone # ______________________

I ______________________ sustained personal injury or occupational disease on the ____________ day

of ______________________ , in the Province (or Territory, State, etc.) of ______________________

while in the employ of ______________________

OR (in case of a death)

I am a dependent of ______________________ , who died on the ____________ day of

______________________ , as a result of a work-related injury or an occupational disease sustained in the

Province (or Territory, State, etc.) of ______________________

I must choose whether I will claim compensation under the *Workplace Health, Safety and Compensation Act* of Newfoundland and Labrador or claim compensation (or damages) under the law of the Province (or Territory, State, etc.) where the injury (or occupational disease or fatality) occurred.

Having considered the matter, I elect to claim compensation for this injury (or occupational disease or fatality) under the *Workplace Health, Safety and Compensation Act* of ______________________ .

Should my claim be accepted, I waive and forego any rights to compensation in any other jurisdiction, and will not apply for or accept any benefits from such other jurisdiction unless authorized to do so by WorkplaceNL of Newfoundland and Labrador.

I understand this election to claim compensation will be forwarded to the Compensation Board in the Province (or Territory, State, etc.) where the injury (or occupational disease or fatality) occurred.

Dated this ____________ day of ______________ , ________ , at ______________________

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(Signature)