

This form may only be completed by the injured worker or authorized representative (person authorized to represent injured worker requires completion of Form 13 or appropriate consent).

1. Worker Information				
Last Name		First Name		Claim Number(s)
Mailing Address				
City/Town		Province	Postal Code	Telephone ()
For purposes of file search, if you do not know the claim number(s) please include the following information: Other Names (e.g., maiden name, middle name etc.)				
Date of Birth (yyyy/mm/dd)		Social Insurance Number		MCP
Please choose one option:				
<input type="checkbox"/> Copy of file information to be sent to worker at the above address. (Please continue to section 2.) OR <input type="checkbox"/> Copy of file information to be sent to authorized representative or a third party. (Please provide mailing address below and continue to section 2.)				
Name of Authorized Representative/Third Party				
Name of Organization				
Mailing Address				
City/Town		Province	Postal Code	Telephone ()

2. File Information Requested	
Please indicate what file information you require to be copied and indicate if for Internal Review Appeal. Please note applicable charges may apply.	
<input type="checkbox"/> Updates only	<input type="checkbox"/> For Internal Review Appeal
<input type="checkbox"/> Medical information	
<input type="checkbox"/> All-full file	<input type="checkbox"/> Other, please specify _____

3. Authorization	
I, the injured worker or authorized representative, consent to the disclosure by WorkplaceNL of the requested information to me or authorized representative/third party indicated above. I understand this may include sensitive information, including past medical history .	
Name (please print)	
Signature of Worker or Authorized Representative	Date (yyyy/mm/dd)

Personal information contained on this form is collected under the *Workplace Health, Safety and Compensation Act* and will be used to respond to your request. If you have any questions regarding this request for file information or applicable fees, please contact the Internal Review Clerk at: 709.778.4139 or toll-free at: 1.800.563.9000

For WorkplaceNL only
