

Worker or Employer name _____ Claim or Firm Number _____

Check one:

- I am the injured worker
- I am the employer
- I am the authorized representative

To request a review of a WorkplaceNL decision, please state:

- The decision you disagree with

- The date of the decision _____
- The name of the decision maker _____
- The reasons you disagree with the decision (add another sheet or document(s) if required)

- Are you sending extra information with this form? Yes No

Authorized Representative, if applicable. (Please note a Form 13: Authorized Representative must be completed.)

Name of Authorized Representative	Telephone number of Authorized Representative
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Address of Authorized Representative _____

Signature	Date
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