WorkplaceNL

Email form to: internalreview@workplacenl.ca
Fax form to: 709.778.1586
Visit us at: workplacenl.ca

Call us at:
t 709.778.1000
t 1.800.563.9000

Request for File Information

To be completed by the injured worker, the employer or their designated authorized representative.

1. Worker Information

Last Name	First Name	Claim Number(s)
Mailing Address		

City/Town	Province	Postal Code	Telephone ( )

2. Other Information

If you do not know the claim number(s) an Internal Review Clerk will contact you.

Please choose one option:

☐ Copy of file information to be sent to worker at the above address. (Please continue to section 3.)

OR

☐ Copy of file information to be sent to employer, designated authorized representative or a third party (Please provide mailing address below and continue to section 3.)

Name of Employer, Designated Authorized Representative or Third Party

Name of Organization

Mailing Address

City/Town	Province	Postal Code	Telephone ( )

3. File Information Requested

What file information are you requesting? Please indicate if related to a Request for Internal Review. Please note applicable charges may apply.

☐ Updates only ☐ For Internal Review
☐ Medical information ☐ Medical and rehabilitation information
☐ All-full file ☐ Other, please specify ____________________

4. Authorization/Undersigned

I, the undersigned, consent to the disclosure by WorkplaceNL of the requested information to me, the authorized representative, or third party indicated above. I understand this may include sensitive information, including **past medical history.**

Name (please print)

Signature of Worker, Employer or Designated 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 call us at: 709.778.1000

For WorkplaceNL only