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 Internal Review

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

Address of Authorized Representative _____

_____

_____ _____

Signature | Date

If you need assistance, please email us at: internalreview@workplacenl.ca
or call: 709.778.1000 or 1.800.563.9000