

You must complete, sign and return this form to WCAT within 30 days of the Review Division decision being appealed. Make sure that you answer every question. We only require the basic information on this form to start your appeal. You will have an opportunity later on to provide more information to support your appeal. If you are sending this form after the 30 day time limit you also need to apply for an extension of time to appeal. You can find the Application for an *Extension of Time to Appeal* on our website (www.wcat.bc.ca) under the Forms tab, or call us and we will send you the form.

1. WORKER CLAIM INFORMATION

| | | |
|----------------------------|---------------------------------------|--|
| Worker Last Name | Worker First Name | <input type="checkbox"/> Mr. or <input type="checkbox"/> Ms. |
| WorkSafeBC Claim Number(s) | WorkSafeBC Customer Care # (if known) | |

2. INFORMATION ABOUT YOU (APPELLANT)

To keep your appeal active you must tell us about changes in this information.

| | | |
|--|-----------------------|---|
| <input type="checkbox"/> I am the worker | Worker BC Care Card # | |
| <input type="checkbox"/> I am the employer | Employer Firm Name | Job Title of Employer Contact named below |
| <input type="checkbox"/> I am the dependant of a deceased worker | | |

| | | |
|--------------------------------|------------------------------|--|
| My Last Name | My First Name | <input type="checkbox"/> Mr. or <input type="checkbox"/> Ms. |
| Mailing Address | | |
| City/Town | Province | Postal Code |
| Telephone (Daytime) () | Telephone (Other) () | Fax Number () |

3. REVIEW DECISIONS

A Review Division decision may decide more than one request for review. List below each Review Reference # you are appealing.

| | | | | |
|--|-------------|-------------|---|-------------|
| Review Division Reference #(s): | | | | |
| 1) R | 2) R | 3) R | 4) R | 5) R |
| Date of Review Decision you are appealing (YYYY-MM-DD) | | | Please attach a copy of the first page of the Review Division decision. <input type="checkbox"/> Copy is attached | |

4. REASON FOR APPEAL

Provide a brief answer for each Review Reference # you wish to appeal.

| |
|---|
| The decision is wrong or should be changed because: |
| (please attach additional page(s) if necessary) |

5. RESULT/BENEFITS REQUESTED FROM APPEAL

Provide a brief answer for each Review Reference # you wish to appeal.

| |
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| I request the following result or benefits from this appeal: |
| (please attach additional page(s) if necessary) |

6. WorkSafeBC DISCLOSURE

Your copy of the WorkSafeBC file will be sent in CD format unless you request a paper copy.

| |
|--|
| <input type="checkbox"/> CD COPY <input type="checkbox"/> PAPER COPY |
|--|

Worker Last Name _____ WorkSafeBC Claim Number(s) _____

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| 7. METHOD OF APPEAL | WCAT will decide how your appeal will proceed. Please indicate your preference below: |
| <input type="checkbox"/> In writing (through written submissions) <input type="checkbox"/> Verbally (at an oral hearing) | |
| If requesting an oral hearing, tell us why an oral hearing is necessary: | |
| If WCAT decides to hold an oral hearing, I would like it to take place in: | |
| <input type="checkbox"/> Castlegar <input type="checkbox"/> Cranbrook <input type="checkbox"/> Kamloops <input type="checkbox"/> Nanaimo <input type="checkbox"/> Richmond <input type="checkbox"/> Victoria <input type="checkbox"/> Courtenay <input type="checkbox"/> Fort St. John <input type="checkbox"/> Kelowna <input type="checkbox"/> Prince George <input type="checkbox"/> Terrace <input type="checkbox"/> Williams Lake | |
| NOTE: WCAT provides professional interpreters. Family and friends may not interpret for you. If an oral hearing is held, do you need an interpreter? | |
| <input type="checkbox"/> No <input type="checkbox"/> Yes the language I speak is _____ Dialect _____ | |
| If an oral hearing is held, do you plan to bring any witnesses to the hearing? <input type="checkbox"/> No <input type="checkbox"/> Yes | |

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| 8. REPRESENTATION | You may appoint on person or an organization to represent you or choose to represent yourself. Please indicate your choice below. |
| Will you be representing yourself? <input type="checkbox"/> Yes (go to next section) <input type="checkbox"/> No (please choose one of the following): | |
| <input type="checkbox"/> I want to appoint an organization as my representative | Name of Organization |
| <input type="checkbox"/> I want to appoint one person to represent me | Relationship to Person (e.g. family member or friend) |
| Last Name of Representative/Organization Contact | |
| First Name of Representative/Organization Contact | |
| <input type="checkbox"/> Mr. or <input type="checkbox"/> Ms. | |
| Mailing Address | |
| City | |
| Province | |
| Postal Code | |
| Telephone (Daytime) () | |
| Telephone (Other) () | |
| Fax Number () | |
| This form must be signed by the appellant or an authorized representative. If signed by an authorized representative we need an authorization less than 2 years old signed by the appellant. An <i>Authorization of Representative</i> form can be found on our website (www.wcat.bc.ca). | |
| That authorization <input type="checkbox"/> is enclosed. <input type="checkbox"/> is on the WorkSafeBC file. | |

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| 9. CERTIFICATION AND AUTHORIZATION |
| I confirm the information on this form is correct and complete. I will notify WCAT if I change my address or phone number. I understand that WCAT must have my current address to keep my appeal active. I authorize my representative named above to act on my behalf in this appeal. |
| For workers: I authorize disclosure of my claim file(s) and information relating to this appeal to WCAT, my representative, and other parties to this appeal for the purposes of this appeal and as allowed under section 260 of the <i>Workers Compensation Act</i> . I also authorize WCAT to obtain or view from any source a copy of my employment or medical records of any other documents that may relate to the Review Division decision. |
| Signature of appellant or authorized representative |
| Date Signed: (YYYY-MM-DD) |
| X |

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|---|
| 10. FORM CHECK-LIST |
| <input type="checkbox"/> Number of additional pages attached? ____ <input type="checkbox"/> Did you provide Worker Last Name and WorkSafeBC Claim Number(s) on the top of this page? |
| <input type="checkbox"/> Did you attach a copy of the first page of the Review Division decision(s) you wish to appeal? |
| <input type="checkbox"/> If your appeal is later than 30 days, did you attach a completed <i>Extension of Time to Appeal</i> form (found at www.wcat.bc.ca or call us for one)? |
| <input type="checkbox"/> Have you signed in Box 9 above? |
| <input type="checkbox"/> Did you answer all questions? Call us if you need help filling out this form. Send this form as soon as it is complete. |

Personal information on this form is collected for the processing and adjudication of a WCAT matter under the *Workers Compensation Act* and the *Freedom of Information and Protection of Privacy Act*. For further privacy information, please contact WCAT's Freedom of Information Coordinator at the address or telephone number on the top of this form.