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Website: www.wcat.bc.ca Email Address for Filing Documents: appeals@wcat.bc.ca

This form allows WCAT to obtain information about a worker relating to matters before WCAT, and to release information to other parties or participants.

If you are printing this blank document and filling it in by hand, please print clearly using black or blue ink.

1. IDENTIFY THE APPEAL

The appeal was started by (appellant's name):		WCAT No.(s)
Date of decision appealed (YYYY-MM-DD)	WorkSafeBC File/Firm #(s)	Review Division Reference #(s) (if applicable)

2. INFORMATION ABOUT YOU (THE WORKER)

Your Full Name		Date of Birth (YYYY-MM-DD)	
Mailing Address			
City/Town		Province	Postal Code
Telephone (Daytime) extension:	Telephone (Other) extension:	Fax Number	

3. CERTIFICATION AND AUTHORIZATION

If you are filing your authorization by email (appeals@wcat.bc.ca), complete section a).
If you are filing your authorization by facsimile or Canada Post, complete section b).

a) **For submitting your authorization by email:**
I, _____, understand that checking this box constitutes a legal signature confirming that I acknowledge and agree to the following:

I authorize disclosure of my WorkSafeBC 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 314 of the *Workers Compensation Act*. I also authorize WCAT to obtain or view a copy of my medical and employment records from any source, including physicians, health practitioners, medical insurers, hospitals and employers.

b) **For submitting your authorization by facsimile or Canada Post, the form must be signed.**
I authorize disclosure of my WorkSafeBC 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 314 of the *Workers Compensation Act*. I also authorize WCAT to obtain or view a copy of my medical and employment records from any source, including physicians, health practitioners, medical insurers, hospitals, and employers.

Signature (You, not your representative, must sign here) **Date Signed: (YYYY-MM-DD)**
X

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 information, please contact WCAT's Freedom of Information Coordinator at the address or telephone number on the top of this form. Email is not a secure medium. Any message or attachment you send by email could be intercepted and read by someone else, and you accept the risk of access to personal information by unauthorized persons during transmission. WCAT accepts no responsibility for messages or attachments sent by email until they are received by WCAT. You are responsible for the security of information you are sending. You must assess its sensitivity and decide whether email is a secure enough method of communication.