

WROI

Request for Copy of File

Name _____ WCB Claim Number _____

If you are interested in requesting a review of a decision made on your claim, Section 171.1(1) of *The Workers' Compensation Act* provides authorization for access to a copy of your file.

To receive a copy of your file, fully complete and return this form to the Workers' Compensation Board.

Describe the decision that you don't agree with:

What is the date of the letter describing the decision you don't agree with? _____

According to the provisions of Section 171.1(1), the information contained in your file cannot be used publicly or for any other purpose than pursuing your claim with the Workers' Compensation Board.

Sensitive medical information may be sent to your physician rather than directly to you. You will be notified if this occurs.

If you would like your file copy sent to your representative:

1. Please complete Section A.
2. **Note:** A completed "[Authorization Letter of Representation](#)" is also required prior to your file copy being released to your representative.

If you complete Section A, a copy of your claim will only be sent to the representative you identify.

Section A	
Representative's Name	_____
Address	_____
City	_____ Province _____ Postal Code _____
Phone	_____ Fax _____
E-Mail	_____

Your request for a copy of the file is NOT a request for an appeal.

Date _____

Signed _____ (Your signature)

Name: _____ (Please print)