Saskatchewan Workers' Compensation Board

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Attn: WCB health-care services quality assurance — administrative assistant

Accreditation request – assessment team member

To be completed by team chair

Name of care provider applicant: _____

Name of team member the applicant is replacing: _____

Applicant will be: ☐ Core member ☐ Alternate member ☐ Second alternate member

Name of team: _____

Type: ☐ Secondary physical assessment ☐ Tertiary physical assessment

☐ Mental health assessment ☐ Head trauma assessment

The WCB can confirm information by contacting:

Name: _____ Phone: _____

With this application, include the documents that demonstrate how the applicant meets the accreditation requirements. Submit these documents with each application, even if you have submitted them with a previous accreditation request.

Team chair: Name: _____

Address: _____

City/town: _____

Postal code: _____

Phone: _____

Fax: _____

I confirm that this team complement continues to meet the WCB's requirements for members with treatment team experience.

_____ _____

Signature of team chair Date

CLEAR FORM