G. *SAMPLE AUTHORIZATION BY WORKER OR DEPENDANT FORM*

AUTHORIZATION BY WORKER OR DEPENDANT

I, _____, residing at _____
(Print Name) (Full Address)

_____, _____,
(City & Postal Code) (Telephone Number)

authorize the following:

_____
(Print Name/Title of Representative)

_____
(Representative's Full Address/Organization Name)

_____

_____
(Postal Code) (Telephone Number) (FAX Number, if available)

to be my representative respecting Workers' Compensation Board ("WCB") matters, including any review before the Review Division.

I authorize my representative to obtain or view, from any source whatsoever, including records of physicians, qualified practitioners or hospitals, a copy of records pertaining to my examination, treatment history, and employment. For the purpose of reviews, I consent to the WCB disclosing to my representative the contents of my WCB claim file(s) or any other WCB file(s) or related information to which I am eligible to receive disclosure. I further authorize my representative to act on my behalf in providing evidence and submissions in reviews of such WCB files.

I also acknowledge the WCB may obtain or view, from any source whatsoever, a copy of records respecting the matter(s) under review.

This authorization shall remain in effect for two (2) years, or until I revoke it in writing or until my death, whichever is earlier.

_____ _____
Signature of Worker or Dependant Date

April, 22, 2003