

Request for Review

				Claim Number: (for requests on claim decisions)				
				Employer Number: (for requests on account decisions)				
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Contact Information (Advise to I am the: □ Worker □ Em		ommittee in writin	ng if this)	
Tailitile. 🗆 Worker 🗀 Eili	ALTIEI	My title/position is:						
Last Name:		First Name:			Emp		loyer Name:	
Mailing Address:		City:		Province/Territ		ory:	Postal Code:	
Home # (include area code): Work # (i		clude area code): Fax #		include	include area code		E-mail Address:	
Review Request (Attach additional sheets if necessary.)								
I disagree with the WSCC de	cision letter d	lated:						
Issue(s) I disagree with:								
Reason(s) I disagree with the decision:								
ype of Review Requested (R	eview Comm	ittee does not rei	mburse	travel	costs or t	time m	nissed from wor	rk.)
☐ Documentary Review	Г	☐ Oral Hearing –	Select T	уре	○ In-pe	erson	○ Telephor	ne O Video Conference
Representation (If you have a	representativ	e, provide the foll	lowing ii	nforma	tion.)			
Representative/Agency Name		Phone Number (include area code): Address:						
1		aut	horize t	he Wo	rkers' Saf	fety &	Compensation	Commission of the
Northwest Territories and Nur								
The WSCC may use this infor	mation for t	he administratio	n of the	e Work	ers' Com	npens	ation Acts, the	Safety Acts, and/or the
fline Health and Safety Acts,	and their as	ssociated Regula	ations.					
I understand when the appell	ant is a work	er, the employer i	may par	ticipat	e, and red	ceive o	copies of all do	cuments used, in the review.
MM DD YY								
Applicant's Signature			_	Date				

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