

Claim Number(s): _____

I, _____, request a photocopy of my file(s), in accordance with the Workers' Compensation Act, be sent to:

Client
Street _____

City _____
Province _____ Postal code _____
Phone Number _____

Representative
Street _____

City _____
Province _____ Postal code _____
Phone Number _____

Client Signature

Date

By checking here I acknowledge that the information provided in this form is true and accurate. I understand I am providing informed consent to authorize WCB Nova Scotia to release information about my claim to the individual/organization noted above, until I request otherwise in writing.

By submitting this form, I confirm that the information provided on this form is true and accurate. I understand this information may be subject to audit and the WCB may rely on this information in adjudicating my claim.

**This request is valid for 12 months from the date it is received at WCB Nova Scotia offices.
Renewal will not be initiated by the WCB Nova Scotia.**

Please return the completed form to:

Photocopy Clerk
WCB Nova Scotia
PO Box 1150
5668 South Street
Halifax, NS B3J 2Y2