Clear Form

WORK SAFE. FOR LIFE.
WORKERS' COMPENSATION BOARD OF NOVA SCOTIA

Notice of Appeal to Hearing Officer — WORKER APPEAL

Mailing Address
Internal Appeals
Department
PO Box 1150
Halifax NS B3J 2Y2

Street Address
Fenwick Medical Centre
5595 Fenwick Street,
Suite 306
Halifax NS

Contact Numbers
Local: 902-491-8800
Toll free: 1-800-870-3331
Facsimile: 902-491-8001

Claim #:

WORKER: Please complete this Notice of Appeal form **in full** and submit it along with all relevant supporting information. This form is due to **the WCB Nova Scotia within 30 days** of receiving a written decision in the mail.

A. INFORMATION REQUIRED

Worker's Name:			
Address:	City/Town:	Province: NS	Postal Code:
Telephone:	Fax:		
Name of Employer When Injury Occurred:			

B. DECISION TO BE APPEALED

I wish to appeal the WCB Nova Scotia decision made by _____ dated dd | mm | yyyy
(caseworker)

I believe the decision maker made the following error: (Please be specific as you can and use extra paper if necessary.)

Have you discussed this error with your caseworker? Yes ☐ No ☐

The benefits/remedy I am seeking includes: (Please be specific as you can and use extra paper if necessary.)

Form continues next page

C. APPEAL ASSISTANCE

☐ I intend to represent myself during the appeal process. Yes ☐ No ☐

Workers may also seek assistance through the Workers' Advisers Program, which can be reached at 902-424-5050 in Halifax or toll free across Nova Scotia at 1-800-774-4712. They can also be reached through this website www.novascotia.ca/lae/wap. If you intend to seek representation through the Workers' Advisers Program, this should be done immediately to ensure they have sufficient time to establish your eligibility.

☐ I have contacted the Workers' Advisers Program and am awaiting confirmation regarding representation.
I give permission to the Workers' Advisers Program to obtain a copy of my file. Yes ☐ No ☐

☐ If you already have a representative, please provide the following information.

Name of Representative:			
Name of Firm/Organization:			
Address:	City/Town:	Province: NS	Postal Code:
Telephone:	Fax:		

D. APPEAL PROCESS

Once we receive this form, we will contact you (or your representative) by telephone to review the Internal Appeals process, clarify the issue you are appealing and answer any questions you may have.

IMPORTANT: If the Notice of Appeal form (noting the specific reasons for your appeal) and relevant supporting information are not **received at WCB Nova Scotia within 30 days** of receiving the original claim decision by mail, the appeal may not be accepted, and the original claim decision will become the final decision of the WCB.

NOTE: To protect your privacy, do not email this form. Please send it by mail or fax.

Signature of Worker or Representative

Date