wcb Workers' Compensation Board – Alberta
PO Box 2415
Edmonton AB T5J 2S5
Fax: (780) 498-7867

C1096
EMPLOYER REQUEST FOR CLAIM FILE DOCUMENTS

Billing #:0G1N

1.

Worker's *Surname*	*First Name*	*Initial*	WCB Claim Number

Employer Name	Employer Account Number

2.

Applicant: ☐ Employer ☐ Employer Rep

Applicant's Name	Company Name

Address *Street*	*City/Town*	*Province*	*Postal Code*

Fax Number ( )	Telephone Number ( )

3.

Request for specific claim file documents: please be specific, for example: name, date and type of document:

I am authorized by the above noted employer to request claim file(s) or claim file documents from the WCB. I acknowledge that this information is being requested and provided under the authority of the Workers' Compensation Act (the "WCA") for the following purposes:

Facilitate return to work planning, understand progress of medical and vocational rehabilitation and decisions made by the WCB*****; Contemplate and/or advance a Review before the Dispute Resolution and Decision Review Body or Appeal before the Appeals Commission [section 147(3)].

Where information is obtained under section 147(3) of the WCA, that information may only be used for the purpose of a review or appeal under that WCA. I acknowledge that if the information is used for any other purpose without the consent of the WCB I may be guilty of an offense (section 152) or charged an administrative penalty (section 152.1) under the WCA. I also acknowledge that I may be subject to other provincial and federal privacy law and other legislation that places further limits to my use and disclosure of the information provided to me by the WCB and it is my obligation to ensure compliance.

Date:(yyyy-mm-dd) **Print name:** **Signature**_____

*****In accordance with WCB's authority under Sections 35, 44, and 147(2) of the WCA

Claim File to be: ☐ Faxed ☐ Mailed ☐ Picked-up Edmonton ☐ Picked-up Calgary

☐ Emailed via WCB secure file transfer service. If secure delivery is selected, please provide email and password (6 to 8 characters).

Email _____ Password_____

Please print, sign, and date this form then fax to (780) 498-7867 or email to: ati@wcb.ab.ca

Completed by Access to Information