

**WORK SAFE. FOR LIFE.**

**Notice of Appeal to Hearing Officer – EMPLOYER APPEAL**

WORKERS' COMPENSATION BOARD OF NOVA SCOTIA

Internal Appeals, PO Box 1150, Halifax, Nova Scotia B3J 2Y2 Local: 902-491-8800 Toll free: 1-800-870-3331 Fax: 902-491-8001

**EMPLOYER:** Please complete this form **in full** and submit it along with all relevant supporting information. A Notice of Appeal is due to **WCB Nova Scotia within 30 days** of receiving a written decision. If the Notice of Appeal form is not received within those 30 days, the appeal may not be accepted, and the original decision will become the final decision of WCB Nova Scotia.

CLAIM APPEAL NUMBER: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
BUSINESS NUMBER: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>

**A. INFORMATION REQUIRED**

Employer Name:		Name of Representative Filing Appeal:		
Address:		City/Town:	Province:	Postal Code:
Telephone:	Fax:			
Name of Worker (if Claim Appeal):				

**B. DECISION TO BE APPEALED – Please be as specific in your answers as you can, and attach extra paper if necessary.**

I wish to appeal the WCB Nova Scotia decision made by \_\_\_\_\_ dated dd | mm | yyyy

I believe the decision maker made the following error:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Have you discussed this error with the decision maker? Yes  No

The benefits/remedy I am seeking includes:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**C. APPEAL ASSISTANCE**

Employers may also seek assistance through the Office of the Employer Advisor, Nova Scotia Society (OEA NS). You can contact OEA NS at info@oceans.ca or 902-442-9366.

The Employer has contacted the OEA for assistance with this appeal. Yes  No

**D. APPEAL PROCESS**

Upon receipt, we will contact you or your representative by phone to review the process, and answer any questions you may have.

\_\_\_\_\_  
 Authorized Signature on behalf of the Employer

\_\_\_\_\_  
 Date

**PLEASE NOTE:** To protect the privacy of your worker and your confidential business information, do not email this form. You can attach the form in a secure message using MyAccount, or you can send it by mail or fax.