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

WCB Nova Scotia
PO Box 1150
Halifax, Nova Scotia B3J 2Y2
Toll-free: 1.800.870.3331
Fax: 902.491.8001

Employer Representative Authorization Form

Visit our website: wcb.ns.ca

PRINT RESET SAVE

This form authorizes _____ (Name of Authorized Representative), to act as the Authorized Representative of _____ (The Employer), in relation to _____ (Injured Worker Name) Date of Injury _____ (MM/DD/YYYY) or WCB Claim Number _____ (7 digit WCB Claim Number) for the 12-month period _____ (MM/DD/YYYY) to _____ (MM/DD/YYYY).

In accordance with this authorization, the Workers' Compensation Board of Nova Scotia (the WCB) may share reasonable information from the WCB file with the above named Representative in accordance with WCB policies. Information regarding a WCB claim will not be released to the Representative unless a signed authorization form is on the WCB claim file.

I confirm that I have the Employers' authorization to appoint a Representative to act on behalf of the Employer with respect to matters relating to the claim noted above. I understand that the Representative may act on behalf of the Employer until otherwise indicated in writing. The Employer understands and accepts that a revised authorization form must be completed at a minimum annually, or upon any changes to the status of the Representative.

The Employer accepts their responsibility to ensure the privacy and confidentiality of the information shared with them is maintained by the Representative.

Signature of Authorized Employer Representative:	Title:
Date: (MM/DD/YYYY)	

Please submit this completed form as a secure message attachment in **MyAccount**, fax it to **902.491.8001** or mail to:
WCB Nova Scotia, PO Box 1150, 5668 South Street, Halifax, NS B3J 2Y2

JULY/2024