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This form authorizes _____ (Name of Authorized Representative), to act as the Authorized Representative of _____ (The Employer), concerning 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.

Employer Signature:

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, 200-137 Venture Run, Dartmouth, NS B3B 0L9