THE APPEAL COMMISSION
THE WORKERS COMPENSATION ACT OF MANITOBA

EMPLOYER APPEAL OF CLAIMS DECISION

TO: THE APPEAL COMMISSION
600 - 330 St. Mary Avenue
Winnipeg MB R3C 3Z5

Telephone: (204) 925-6116
Fax: (204) 943-4393
Toll Free: 1 (855) 925-6110

☎ Should you have any questions when completing this form, please call ☎
the **Assistant Scheduling Coordinator** at (204) 925-6116 or toll free at 1 (855) 925-6110

A.

THIS APPEAL IS REQUESTED BY:

Employer Name: _____ Account Number: _____

Address: _____

City/Town: _____ Province: _____ Postal Code: _____

Telephone Number: _____ Email: _____

B.

Name of Worker:

Claim Number:

C.

Name of Representative:
(if applicable) _____

Address: _____

City/town: _____ Postal Code: _____

Telephone Number: _____ Fax Number: _____

If you will be represented on your appeal, you must provide a separate signed and dated authorization naming your representative*

D.

Any required interpretation services will be arranged by the Appeal Commission.

Please check here if you require the services of an interpreter: ☐

Please indicate the type of Language:

E.

I wish to appeal the decision of the WCB Review Office dated: _____

The decision(s) I wish to appeal is (are):

I believe this decision of the WCB Review Office should be overturned for the following reasons:

NOTE:
If additional written evidence is to be submitted, this should be forwarded to the Appeal Commission at least 5 business days prior to the hearing.

F.

METHOD OF APPEAL: Please refer to the attached brochure and indicate by which method you wish to pursue your appeal. (please check one):

ORAL HEARING ☐ FILE REVIEW ☐

If you are requesting a hearing, please state the reasons why you consider that a hearing is necessary:

➤ *The Chief Appeal Commissioner has the final authority to determine the method of appeal.* ➤

SIGNATURE: _____ DATE: _____