





## APPEAL OF VICTIM COMPENSATION 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:

Claimant Name: \_\_\_\_\_ Claim Number: \_\_\_\_\_

Address: \_\_\_\_\_

City/Town: \_\_\_\_\_ Province: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Phone Number (home): \_\_\_\_\_ (work): \_\_\_\_\_ Email: \_\_\_\_\_

### B.

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\****

### C.

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:

**D.**

I wish to appeal the decision of the Program Director dated: \_\_\_\_\_  
The decision(s) I wish to appeal is (are):

I believe the decision of the Program Director 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.*

**E.**

**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: \_\_\_\_\_