THE APPEAL COMMISSION
THE WORKERS COMPENSATION ACT OF MANITOBA

WORKER APPEAL OF CLAIMS DECISION

TO: THE APPEAL COMMISSION
1120 - 330 St. Mary Avenue
Winnipeg MB R3C 3Z5

Telephone: (204) 925-6110
Toll Free: 1 (855) 925-6110
Fax: (204) 943-4393
Email: appeal@appeal.mb.ca

Should you have any questions when completing this form, please contact the **Scheduling Assistant** at (204) 925-6116, toll free at 1 (855) 925-6110 or by email at appeal@appeal.mb.ca

A.

THIS APPEAL IS REQUESTED BY:

Worker Name: _____ Preferred Pronouns (Optional): _____

Claim Number: _____

Address: _____

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

Phone Number (home): _____ (cell) _____ Email: _____

B.

Name of Representative: (if applicable) _____

Address: _____

City/town: _____ Postal Code: _____

Telephone Number: _____ Email: _____

If represented on your appeal, you must provide a separate authorization naming your representative

C.

Employer when injury/disease occurred:

D.

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

Please check here if you require a hearing in French: ☐

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

Please indicate Language and dialect: _____

Available in alternate format on request

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E.

ACCOMODATION: Accommodations are arrangements that allow persons of all abilities to participate fully in the appeal process. If you want to request an accommodation to participate in the appeal process at the Appeal Commission, please tell us about your accommodation needs. Provide as much information as you can so we can consider your request and respond.

If you need help with the form or are unable to complete the form, please call us.

F.

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 providing additional written evidence or submission, this must be sent to the Appeal Commission at least 5 business days prior to the hearing.

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G.

METHOD OF APPEAL: Please indicate how you want your appeal heard. (please check one):

VIDEOCONFERENCE ☐ IN OFFICE AT 330 ST. MARY AVE ☐

TELECONFERENCE ☐ FILE REVIEW ☐

If requesting an appeal other than file review, please state the reasons why you consider a hearing is necessary:

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

SIGNATURE: _____ DATE: _____