



WORKER APPEAL OF CLAIMS DECISION

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

Telephone: (204) 925-6110
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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: _____	Claim Number: _____	
Address: _____		
City/Town: _____	Province: _____	Postal Code: _____
Phone Number (home): _____	(work) _____	Email: _____

B.

Employer when injury/disease occurred: _____

C.

Name of Representative: (if applicable) _____	
Address: _____	
City/town: _____	Postal Code: _____
Telephone Number: _____	Email: _____

****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: _____

**If you require accommodation at a hearing due to an accessibility barrier
please let us know how we can help**



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 providing additional written evidence or submission, this must be sent 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):

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: _____