



Workplace Safety and Insurance Appeals Tribunal

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Notice of Appeal for Employers

WSIAT No. _____

Company Name: _____

We wish to appeal the decision of: _____ dd / mm / yyyy Firm Number: _____

1. CONTACT INFORMATION

First Name _____ Last Name _____

Address (Street Number and Street) _____ Suite/Unit Number _____

City/Town _____ Province _____ Postal Code _____

Work Telephone Number (+ ext) _____ Fax Number _____ **Please write to me in:** English French

2. REPRESENTATION

First Name _____ Last Name _____ LSO Category: Lawyer Paralegal Exempt
(Choose one)

Company, Association or Organization Name _____

Address (Street Number and Street) _____ Suite/Unit Number _____

City/Town _____ Province _____ Postal Code _____

Or We will represent ourselves. _____
Work Telephone Number _____ Fax Number _____

3. WORKER'S INFORMATION (IF APPLICABLE TO APPEAL)

First Name _____ Last Name _____

Address (Street Number and Street) _____ Suite/Unit Number _____

City/Town _____ Province _____ Postal Code _____

Home Telephone Number _____ Work Telephone Number _____

Claim Number: _____ Date of Accident: _____ dd / mm / yyyy

4. ISSUES I WANT TO APPEAL

Please refer to the WSIB decision you are appealing and choose either A or B.

- Or
- A)** We are appealing all of the issues in the decision.
- B)** We are appealing only the issues of:

5. THE REASONS FOR THIS APPEAL

We believe the decision is incorrect or should be changed because:

- the evidence was not properly considered.
- law and policy were not properly considered.
- We needed more room to explain our reasons, so we e-filed another page along with this form.

6. IF I WIN THIS APPEAL I WANT THE TRIBUNAL TO:

- We needed more room to explain our reasons, so we uploaded another page along with this form.

7. EMPLOYER'S UNDERTAKING OF CONFIDENTIALITY AND SIGNATURE

I (and any representative I appoint) agree:

- To use the information we receive during the course of this appeal for workplace safety and insurance purposes only and in a manner consistent with Section 59 of the Workplace Safety and Insurance Act.
- To not disclose any documents in the worker's claim file or related claim files or any information forwarded to us by the Tribunal or by the worker in connection with an appeal to a non-party, except in a form calculated to prevent the information from being identified with a particular worker or case.

The above information is correct and sets out all the issues that we intend to raise in this appeal. I understand that copies of this completed form and the decision(s) will be sent to persons who appear to the Tribunal to be interested parties.

Signature: (Please type your first and last name)

Date (dd/mm/yyyy) By checking this box, I understand and agree that my typewritten name and date represent my legal signature

Notice: Information on this form is collected to be utilized in proceedings before the Workplace Safety and Insurance Appeals Tribunal (WSIAT). All information is collected pursuant to the *Workplace Safety and Insurance Act, 1997*, S.O. 1997, c. 16, as amended and will be included in the WSIAT file and provided to the WSIB when the file is returned to the WSIB. This information will only be utilized for workplace safety and insurance purposes. Questions about the collection of information should be directed to the Records Management Coordinator at the WSIAT by calling 416-314-8800 or 1-888-618-8846 (toll-free), or 416-314-1787 (TTY).