Request for Access

Online Services for Employers

Organization:	Name			
	Street	City	Province	Postal code

Delegated Administrator:
Would you like a user ID to be set up with administrative capabilities to create, modify and deactivate Online Services IDs for your organization? (only one administrator per organization)

❑ YES – please provide information below for ONLY the Delegated Administrator.

❑ NO – please identify all individuals in your organization who require access to Online Services.

ID Request:

1.	Name	Position	Access to which application(s)?
	Employer account number(s)		❑ Electronic Injury Reporting
	Phone	Fax	❑ Loss Control Reporting (LCR)
	E-mail address		❑ Account Maintenance

2.	Name	Position	Access to which application(s)?
	Employer account number(s)		❑ Electronic Injury Reporting
	Phone	Fax	❑ Loss Control Reporting (LCR)
	E-mail address		❑ Account Maintenance

3.	Name	Position	Access to which application(s)?
	Employer account number(s)		❑ Electronic Injury Reporting
	Phone	Fax	❑ Loss Control Reporting (LCR)
	E-mail address		❑ Account Maintenance

By signing, I grant approval to create user IDs for the individual(s) named above. I also acknowledge that it is my responsibility to notify the eBusiness Support Team at the Workers' Compensation Board – Alberta when an authorized individual should no longer have access to our system.

By accessing information from a WCB application, I agree that any and all information obtained about any third party, including any worker under the Workers' Compensation Act, shall:

a) be held in the strictest of confidence and in compliance with the Personal Information Protection Act, the Personal Information Protection and Electronic Documents Act and/or the Freedom of Information and Protection of Privacy Act, whichever applies; and

b) not be disclosed to anyone or used in any proceeding, except as is reasonably necessary in proceedings before the Workers' Compensation Board, Appeals Commission or further appeals or applications for judicial review of decisions of those bodies, without the written consent of WCB.

Authorization: (This section is to be completed by applicant's supervisor or manager)	Name *(Please print)*	
	Signature of approval	Position
		Date

Please fax or mail completed application form(s) to:

eBusiness Support Team
Box 2415, Edmonton, Alberta T5J 2S5
Phone: (780) 498-7688 Fax: (780) 498-7866
Email: ebusiness.support@wcb.ab.ca

Comments or questions