Workers' Compensation Board – Alberta
Box 2415
Edmonton, AB T5J 2S5
Fax: 780-498-7867
crs@wcb.ab.ca

# C1096
# EMPLOYER REQUEST FOR CLAIM FILE DOCUMENTS

Billing #: 0G1N

## A. WORKER DETAILS

| Surname | First name and initial | WCB claim number |
|---|---|---|
| Employer name | | Employer account number |

## B. REQUESTOR DETAILS

Requestor

☐ Employer ☐ Employer representative

| Requestor's name | Company name | |
|---|---|---|
| Street | City or town / Province | Postal code |
| Telephone number | Email | Fax number |

## C. REQUEST DETAILS

Please be specific, for example: name, date and type of document being requested.

I am authorized by the above noted employer to request claim file(s) or claim file documents from WCB - Alberta. I acknowledge that this information is being requested and provided under the authority of the *Workers' Compensation Act* (the Act) for the following purposes:

- Facilitate return-to-work planning, understand progress of medical and vocational rehabilitation, and decisions made by WCB*
- Contemplate and/or advance a review before the Dispute Resolution and Decision Review Body or appeal before the Appeals Commission [section 147(3)].

Where information is obtained under section 147(3) of the Act, that information may only be used for the purpose of a review or appeal under the Act. I acknowledge that if the information is used for any other purpose without the consent of WCB I may be guilty of an offense (section 152) or charged an administrative penalty (section 152.1) under the Act. I also acknowledge that I may be subject to other provincial and federal privacy law and other legislation that places further limits to my use and disclosure of the information provided to me by WCB and it is my obligation to ensure compliance.

Signature _____ Printed name _____ Date (YYYY/MM/DD) _____

*In accordance with WCB's authority under sections 35, 44 and 147(2) of the Act.

## DELIVERY METHOD

Documents to be: ☐ Faxed ☐ Mailed ☐ Picked up, Edmonton ☐ Picked up, Calgary

☐ Emailed via WCB secure file transfer service

If secure delivery is selected, please provide email address and password (6-8 characters) below

Email _____ Password _____

**Please complete this form and return it to our office by one of the following methods:**

**Fax: 780-498-7867 Email: crs@wcb.ab.ca**