Notice of Appeal to Hearing Officer

(Rev. 07/2006)

Mailing Address
Workers' Compensation Board
of Nova Scotia
Internal Appeals Department
PO Box 1150
Halifax NS B3J 2Y2

Street Address
Fenwick Medical Centre
5595 Fenwick Street, Suite 306
Halifax NS

Contact Numbers
Local: (902) 491-8800
Toll free: 1-800-870-3331
Facsimile: (902) 491-8801

This Notice of Appeal form must be completed in full and submitted with all relevant supporting information attached. It must be received by the Workers' Compensation Board within 30 days of when you are notified of the WCB decision.

A. INFORMATION REQUIRED

If you are a **WORKER**, complete Section 1. If you are an **EMPLOYER**, complete Section 2.

1. Worker's Appeal

Worker's Name _____ Claim No. _____

Street Address / RR# _____

City / Town _____ Province _____ Postal Code _____

Telephone _____ Fax _____ Email _____

Name of Employer When Injury Occurred _____

2. Employer's Appeal

Employer's Name _____ Firm No. _____

Street Address / RR# _____

City / Town _____ Province _____ Postal Code _____

Telephone _____ Fax _____ Email _____

Name of Worker and Claim # for Decision on Appeal _____

B. DECISION TO BE APPEALED

I wish to appeal the WCB decision made by _____ Dated _____

I believe the decision maker made the following error: (Please be specific. Use extra paper if necessary.)

_____

_____

_____

The benefits / remedy I am seeking include: (Please be specific. Use extra paper if necessary.)

_____

_____

_____

Form continues on reverse

C. REPRESENTATION

Workers and employers may represent themselves during the appeal process. Workers may also seek assistance through the Workers' Advisers Program, which can be reached at (902) 424-5050 in Halifax, or toll free across Nova Scotia at 1-800-774-4712.

If you intend to seek representation through the Workers' Advisers Program, this should be done immediately to ensure they have sufficient time to establish your eligibility.

- I intend to represent myself during the appeal process. Yes [ ] No [ ]
- I have contacted the Workers' Advisers Program and am awaiting confirmation regarding representation. **I give permission to the Workers' Advisers Program to obtain a copy of my file.** Yes [ ] No [ ]

If you already have a representative, please provide the following information:

Name of Representative _____

Name of Firm / Organization _____

Street Address / RR# _____

City / Town _____ Province _____ Postal Code _____

Telephone _____ Fax _____ Email _____

D. METHOD OF APPEAL

The WCB determines if an appeal will proceed by way of an oral hearing or a paper review. Where an appeal proceeds by way of a paper review, no delay will be granted to allow for the submission of additional information. **All information in support of your appeal should accompany this Notice of Appeal form.**

IMPORTANT: If the Notice of Appeal form (noting the *specific* reasons for your appeal) and relevant supporting information are not **received at the WCB within 30 days** of when you are notified of the original claim or assessment decision, the appeal will not be accepted, and the original claim or assessment decision will become the final decision of the WCB.

_____ _____

Signature of Worker, Employer, or Representative Date