



MAIL FORM TO:
146-148 Forest Road P.O. Box 9000
St. John's NL A1A 3B8
FAX FORM TO:
709.778.1302
EMAIL FORM TO:
info@workplacenl.ca

CALL US AT:
t 709.778.1000
t 1.800.563.9000
VISIT US AT:
workplacenl.ca

Please indicate applicable number	<i>Form</i>
CLAIM NUMBER (Worker) <input type="text"/>	13
FIRM NUMBER (Employer) <input type="text"/>	Rev. Oct. 2020

FORM 13 – Authorized Representative Form

Injured workers or employers who want to grant someone else (an authorized representative) access to their claim or employer file must complete a Form 13. A signed Form 13 allows WorkplaceNL to share all file information with the named individual. To have more than one authorized representative, complete and submit one Form 13 for each. To change or remove an authorized representative, complete and submit a new Form 13. For employers, a Form 13 is only required for individuals external to the business.

Your file is associated with a confidential number. For injured workers, it is your **Claim Number**, for employers, it is your **Firm Number**. Your authorized representative is the only other individual who should know your confidential number. For your protection, this number **MUST** be given to WorkplaceNL before any information is shared with you or your authorized representative.

For further information, please consult WorkplaceNL's Information Protection and Access Policy (GP-01) on our website: www.workplacenl.ca.

- I am a worker or dependent; or
 I am an owner, director or authorized signing officer for the business.

I, _____ of _____
print your name business name (employer requests only)

authorize remove check one

_____ of _____
print name of authorized representative (one name only) business name (if applicable)

_____ 289-291-3663
authorized representative mailing address authorized representative phone

to act as my authorized representative.

By signing this form, I understand that my authorized representative may act on my behalf (or on behalf of my business) until I indicate otherwise.

_____ signature signatory phone

_____ job title date of signature

Employers, note that this form does not grant **connect** access. Contact your **connect** firm administrator to add your authorized representative if required.