WORKERS' COMPENSATION APPEALS TRIBUNAL OF NEW BRUNSWICK

Notice of Appeal

This Notice of Appeal must be received by the Appeals Tribunal no later than one year after being notified in writing of the Commission's decision.

Reset

Section 1: Appellant contact information ☐ Worker ☐ Employer

☐ Mr. ☐ Ms.	Appellant last name or company name	Given name(s)
Street		
City/Town	Province	Postal Code

Home	Work	Mobile phone	Fax
Email Address			

If you are an employer, please fill in the boxes on the right.	☐ Mr. ☐ Ms.	Name of the person in the company who is responsible for the appeal	Phone number

Section 2: What are you appealing?

I appeal the following Commission's decision(s):

Name and Claim # or Employer #	Date of the Commission's decision	Attach a copy of the decision
	1.	☐ copy attached
	2.	☐ copy attached
	3.	☐ copy attached

Section 3: What are the grounds?

Grounds (Reasons) for appealing Decision 1:

Grounds (Reasons) for appealing Decision 2:

Grounds (Reasons) for appealing Decision 3:

If there are more grounds, please attach a separate page.

Section 4: Are you challenging a WorkSafeNB policy?

☐ **YES** ☐ **NO** **If YES, which one and the reasons for the challenge:**

Section 5: What language do you prefer? (Choose one)

	English	**French**
Spoken	☐	☐
Written	☐	☐

Section 6: Additional information

If necessary, please use this section to provide any additional information you feel the Workers' Compensation Appeals Tribunal requires in processing your Notice of Appeal.

Section 7: Representation

☐ I have a representative. ☐ I plan to get a representative.	☐ I will represent myself.

If you have a representative, you can complete the information below and sign the authorization.

I appoint and authorize _____ as my representative to act on my behalf in this appeal. My representative's contact information is below.

Name of Representative	Last name		Given name(s)
Company name			
Address	Street		
	City/Town	Province	Postal Code
Telephone:	Work	Mobile phone	Fax

_____ _____

Signature of the representative *Date (dd/mm/yyyy)*

_____

Print name

If you do not have a representative and would like to speak with a workers' advocate or if you are an employer who wishes to speak with an employers' advocate, please call the following toll free number: 1-(844)-530-0282.

Section 8: Are you ready to proceed?

I am ready to have a hearing date scheduled. ☐

I am not ready to have a hearing date scheduled. ☐

Section 9: Signature and date

Note that by filing this appeal, the Workers' Compensation Appeals Tribunal will be sharing all relevant information with the parties involved in the appeal.

_____ _____

Signature *Date (dd/mm/yyyy)*

_____

Print name

As required under subsection 21(2.2) of the *Workplace Health, Safety and Compensation Commission* and *Workers' Compensation Appeals Tribunal Act,* your Notice of Appeal will be delivered/forwarded to the Commission, the Office of the Workers' Advocate and the Office of the Employers' Advocate.

Our address:

Workers' Compensation Appeals Tribunal
P.O. Box 5001
3700 Westfield Road
Saint John, NB E2L 4Y9
ATTENTION: REGISTRAR

Tel: (506) 738-6444
Toll free: 1-844-738-6444
Fax: (506) 738-4104

E-Mail address: WCAT.TAAT@gnb.ca