WSCC Workers' Safety & Compensation Commission | ᐃᖅᑲᓇᐃᔭᖅᑎᓄᑦ ᐊᑦᑕᓇᖅᑐᓂᒃ ᐊᒻᒪ ᓇᓪᓕᐅᒃᑯᒫᓂᒃ ᖃᐅᔨᓴᖅᑎᑦ

REQUEST FOR DISCLOSURE

Please complete all sections and return to the address below:

WORKER'S NAME: _____

SOCIAL INSURANCE NUMBER: _____

ADDRESS: _____

_____

CLAIM NUMBER _____

EMPLOYER'S NAME: _____

☐ **I wish to receive a copy of the above claim file.**

OR

☐ **Send a copy of my above claim file to my representative.**

Representative name: _____

Address: _____

_____

_____ _____

Date **Signature of the worker or dependant**

_____

Telephone number including area code