STATE OF NEW YORK - WORKERS' COMPENSATION BOARD

CHECK ONE ☐ **NOTICE OF RETAINER AND APPEARANCE** ☐ **NOTICE OF SUBSTITUTION AND APPEARANCE**
☐ **NOTICE OF RETAINER AND APPEARANCE - ADDITIONAL ATTORNEY** **(For substitutions, item C MUST also be completed.)**

WCB Case No.	Social Security No.	Date of Accident, Illness or Injury

	Name	Address
CLAIMANT		
EMPLOYER*		
CARRIER		
ATTORNEY OR REPRESENTATIVE	Viola, Cummings & Lindsay	770 Main Street, NF, NY 14301

Representative's ID No., if any	Telephone No. of Atty/Rep.
R-	716-285-9555

*If claim is made under the Volunteer Firefighters' Benefit Law or the Volunteer Ambulance Workers' Benefit Law, show as EMPLOYER the liable political subdivision and enter "X" in the appropriate box..... ☐ VFBL ☐ VAWBL

A. CLAIMANT COMPLETE THIS SECTION

CHECK ONE:

☒ Please take notice that I have retained the above-named firm/individual to represent me in all proceedings concerning my claim.

☐ Please take notice that I have retained the above-named firm/individual to represent me in my appeal to the Supreme Court, Appellate Division, Third Department, or the Court of Appeals.

☐ Please take notice that in place of _____ I have retained the above-named to represent and appear for me in all proceedings concerning my claim.

My claim is under the ☒ Workers' Compensation Law ☐ Volunteer Firefighters' Benefit Law ☐ Volunteer Ambulance Workers' Benefit Law ☐ Disability Benefits Law ☐ Section 120/241 WCL - Discharge or Discrimination Complaint

I hereby authorize the above-named attorney/representative to request and obtain copies of any necessary medical records connected with the Workers' Compensation Board (WCB) case indicated above. In addition, I consent to the transmittal of all medical reports in this case from my health provider(s) to my attorney/representative. I understand and agree that a licensed representative may appear on my behalf at the request of my attorney.

In addition to the case folder for this claim, I authorize the above-named attorney/representative to access (check ONE):

☒ All of my workers' compensation case files maintained by the NYS WCB.
☐ The following workers' compensation case file(s) maintained by the NYS WCB (list by number): _____
☐ No other access permitted.

Claimant's Signature _____ Date _____

B. ATTORNEY/REPRESENTATIVE COMPLETE THIS SECTION

I agree to represent the above-named claimant in compliance with the aforementioned Law and Rules and Regulations promulgated thereunder and hereby notice my retention in the above case. All notices, decisions and other documents are to be sent to the undersigned unless otherwise indicated below. It is understood that the only fees to be paid in this case are those fixed by the WC Law Judge, the Board, the Conciliator or designated employee of the Chair.

I am (CHECK ONE):

☒ An Attorney at Law ☐ A Licensed Representative with Fee--License No._____ ☐ A Licensed Representative without Fee--License No._____

Signature of Attorney/Representative _____ Date _____

ATTORNEY OR REPRESENTATIVE WHO IS TO APPEAR, IF OTHER THAN YOURSELF

Name_____Address_____Tel.No._____will appear in this case. All notices, decisions and other documents should be sent to (him, her or them). Fees, if any should be made payable to:

Name_____Address_____Tel. No._____

C. FOR SUBSTITUTION ONLY - ATTORNEY/REPRESENTATIVE COMPLETE THIS SECTION

A copy of this notice of substitution was served on the _____day of _____,20_____, on

_____ _____
Name of Former Attorney or Representative Address

D. REQUEST AND NOTICE TO HEALTH PROVIDER

Pursuant to Section 13(f) of the Workers' Compensation Law, please transmit copies of all your medical reports to me as the claimant's representative.

Signature of Attorney or Representative appearing for claimant _____

Please Note: A photocopy of this notice shall be deemed as effective as an original.

E. CERTIFICATION OF TRANSMITTAL OF THIS NOTICE TO INSURANCE CARRIER/SELF-INSURED EMPLOYER

I hereby certify that a copy of this notice was transmitted to the insurance carrier or self-insured employer named above at the time of filing with the Board.

_____ _____
Signature of Attorney or Representative Date

NOTICE TO ATTORNEY OR REPRESENTATIVE:

1. This form may be used by an **original, substituted or additional** attorney or representative. Check appropriate box on top of form.
2. Send a copy of this form to **all** of the claimant's health providers.
3. A copy of this form **must** be sent to the workers' compensation insurance carrier or self-insured employer.