WIRO
Workers Compensation independent review office

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Application for review of work capacity decision

This form is issued pursuant to section 44BB(2) of the *Workers Compensation Act 1987*.

Section 1: Your details

Given name(s)

Surname

Address

Suburb | State | Postcode

Telephone number | Mobile

Email

Section 2: Details of decision to be reviewed

Name of insurer

Claim number

Date of insurer decision (DD/MM/YYYY) | Date of decision by the Merit Review Service (DD/MM/YYYY)

Section 3: Grounds for seeking a review

Please provide a short statement explaining why you are seeking a review.

Please attach a copy of your insurer's decision.

Section 4: Authorisation for WIRO

I request and authorise WIRO to send a copy of this application to the insurer on my behalf.

Name

Signature | Date (DD/MM/YYYY)

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