State of Connecticut
Workers' Compensation Commission

Please TYPE or PRINT IN INK

Rev. 3-17-2006

NOA

WCC File #

Date filed in District

(for WCC use only)

Notification of Appearance

I hereby notify the Workers' Compensation Commission _____ District Office regarding the following matter:
(1st-8th)

CLAIMANT _____ v.

RESPONDENT _____

WCC File # *(ONE only)* _____ Date of Injury _____

REPRESENTATION

Your Name _____

Name of Firm _____

Address _____

City/Town _____ State _____ Zip Code _____

Telephone Number _____ Fax Number _____

APPEARANCE

1 — CHECK AT LEAST ONE (1) BOX below and provide the appropriate information for any box(es) you check.

- ☐ I represent the CLAIMANT _____
- ☐ I represent the DEPENDENT SURVIVOR _____
- ☐ I represent the INSURER _____
  - . . . FOR THE EMPLOYER _____
  - . . . FOR THE POLICY PERIOD *(MM/DD/YY - MM/DD/YY)* _____
- ☐ I represent the EMPLOYER *(only)* _____
- ☐ I represent the EMPLOYER FOR § 31-290a CLAIM *(only)* _____
- ☐ I represent the MEDICAL PROVIDER _____
- ☐ I represent ANOTHER PARTY *(please specify)* _____

2 — CHECK ANY APPLICABLE BOX(ES) below and provide the appropriate information for any box(es) you check.

- ☐ I am appearing in lieu of _____
- ☐ I am appearing in addition to _____

3 — DATE AND SIGN this form.

Date _____ Signature _____