Appendix D



**LETTER OF AUTHORIZATION TO REPRESENT PLACEMENT HOST**

***COMPLETE AND SUBMIT THIS FORM WITH A WSIB FORM 7***

***ONLY IN THE EVENT OF AN INJURY***

***This section to be completed by Training Agency***

Please be advised that the following Training Agency is reporting a work related injury on behalf of the placement host identified below and shall serve as the primary contact in matters related to this claim.

Training Agency **Algonquin College**  Firm #  **825018**

Address

City Province  **Ontario**

Postal Code Telephone Number

Placement Coordinator\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ext.\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact  **Occupational Health & Safety (613) 727-4723 ext. 7142**

***This section to be completed by the Placement Host***

 , an unpaid training participant, is claiming that he/she suffered

 (Training Participant’s Name)

a work related injury on while on a Work/Education Placement with our company. (Date)

Company Name Firm #

Address

City Province

Postal Code Telephone Number

Contact Person

Placement Host’s Authorization Signature Date