



## Letter of Authorization to Represent Employer

Please be advised that the following Training Agency (university/college) will serve as the Employer's representative in matters pertaining to WSIB in this work-related injury/disease.

**Training Agency:** Carleton University

**Address:** Human Resources, 507S Robertson Hall

**City, Province:** Ottawa, ON

**Postal Code:** K1S 5B6

**Firm #:** 223774BE

**Contact Person:** Robin Karuna

**Telephone #:** 613-520-2600 ext. 3240

**This section is to be completed by the Placement Employer:**

\_\_\_\_\_, (training participant) the unpaid training participant is claiming that he/she/other suffered a work-related injury or disease on \_\_\_\_\_ (date) while on an unpaid work placement with our company.

**Company Name:** \_\_\_\_\_

**Address:** \_\_\_\_\_

**City, Province:** \_\_\_\_\_

**Postal Code:** \_\_\_\_\_

**Firm #:** \_\_\_\_\_

**Contact Person:** \_\_\_\_\_ **Telephone #:** \_\_\_\_\_

\_\_\_\_\_  
(Placement Employer's Authorized Signature)

\_\_\_\_\_  
(Date)

**Note: This form is to be attached to Form 7 and sent to the WSIB by Carleton University.**