|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| ***Please print clearly or type.*** | WCB Claim Number | Personal Health Number | | Date of Accident *(dd/mm/yyyy)* |
| Worker’s Surname | First Name | | Initial | Date of Birth *(dd/mm/yyyy)* |
| Address Street | City / Town Province | | Postal Code | Home Phone Number |
| Email Address |  |  |  | Cell Phone Number |

|  |  |  |
| --- | --- | --- |
| Claim Owner’s Name and Email | Email | Telephone Number  () |

|  |  |  |
| --- | --- | --- |
| Return to Work Specialist | Email | Telephone Number  () |

**Please schedule the above worker in the next available courses with Archer Training Solution Inc.**



**Refunds will only be provided to clients who notify our office in writing, 2 weeks prior to the start of the course they are enrolled in.**

**Once completed email to: sales@archerts.com**