WORKERS' COMPENSATION COMMISSION

REQUEST TO ENTER APPEARANCE OF COUNSEL

This form is to be used by an attorney only to enter his/her appearance on behalf of a Claimant, SIF, UEF or Healthcare Provider. If you are entering your appearance on behalf of an Employer/Insurer, please use C26R.

WCC Claim Number _____ **Date of Accident** _____

Claimant _____

Employer _____

Healthcare Provider _____

On Behalf of: ○ **Claimant** ○ **SIF** ○ **UEF** ○ **Healthcare Provider**

ATTORNEY INFORMATION: (Complete in Adobe Reader, Print or Type Only)

Name of Counsel _____

WCC Attorney Code/Registration Number: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Office Telephone: _____ Attorney Cell Phone:

Attorney Email: _____

CERTIFICATION OF SERVICE

I hereby certify that on this ____ day of _____, 20___ , service of the foregoing was made to all parties entitled to service in accordance with COMAR 14.09.01.03.

_____

Attorney Signature

CLICK HERE TO CLEAR THE FORM