**LETTER OF AUTHORIZATION TO REPRESENT PLACEMENT EMPLOYER**

**This section is to be completed by the Training Agency (**Ryerson Site**)**

Please be advised that the following Training Agency will serve as the Employer’s representative in matters pertaining to the WSIB in this work related injury.

Training Agency: Toronto Metropolitan University

Address: 350 Victoria Street

City, Province: Toronto, Ontario

Postal Code: M5B 2K3

Contact Person (Instructor/Faculty Advsior): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone Number: 416.979.5000 ext. \_\_\_\_\_\_\_

Ryerson Contact Person (Practice Year Lead Faculty):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone Number: 416.979.5000 ext. \_\_\_\_\_\_\_

**This section to be completed by the Placement Employer (**Placement Agency**)**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_,unpaid training participant is claiming that he/she

(Training Participant’s Name)

suffered a work related injury on \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ while on work placement with our

 (Date) company.

Company Name (Placement Agency):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City, Province \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Postal Code \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact Person \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Placement Employer’s Authorization Signature Date

To be attached to the WSIB Form 7.