



Read [Practice Direction: Fees and Expenses](#) for additional information. Please print.

Injured Worker's Name: _____ WSIAT No. _____
 _____ dd / mm / yyyy
 Hearing Location: _____ Hearing Date: _____ Time: _____

1. PAYEE INFORMATION

Name of Person Claiming Expenses: _____
 Address: _____ Postal Code: _____
 City/Town: _____ Province: _____ Phone: _____

2. OUT-OF-POCKET EXPENSES FOR HEARINGS

NOTE: Out-of-pocket expenses may only be claimed by a worker or worker witness or Tribunal witness who lives outside the metropolitan area where the hearing takes place.

A) MEANS OF TRANSPORTATION (please attach receipts):		AMOUNT CLAIMED
<input type="checkbox"/> Air <input type="checkbox"/> Train <input type="checkbox"/> Bus	_____	Transportation (A): _____
<input type="checkbox"/> Automobile	Kilometres: _____ X 40 cents _____	
B) HOTEL ACCOMMODATION (Receipt must be attached)		Accommodation (B): _____
C) MEALS (Maximum allowance is \$51 per day per person)		
Breakfast: No. of meals _____	Amount: _____ (\$12 max./day/person)	Meal (C): _____
Lunch: No. of meals _____	Amount: _____ (\$16 max./day/person)	
Dinner: No. of meals _____	Amount: _____ (\$23 max./day/person)	
D) PARKING (Maximum allowance is \$5 without receipt, \$10 with receipt)		Parking (D): _____
		TOTAL AMOUNT CLAIMED: _____

E) COMMENTS:

3. ATTENDANCE BY INJURED WORKER OR WITNESS AT THE HEARING

Note: If you lost wages when you attended the hearing as a party or a witness, you may receive a maximum of \$55.48 for a half day and \$110.96 for a full day of lost wages. Any amounts sent with a summons will be deducted.

Did you lose wages on the hearing day(s)? Yes No How many hours? _____

4. SIGNATURE OF PERSON CLAIMING EXPENSES

Signature: _____ Date: _____
 _____ dd / mm / yyyy

*** Please attach all applicable receipts to the Hearing Expense Claim Form.**

FOR OFFICE USE ONLY – DO NOT WRITE BELOW THIS LINE

Witness fee (if loss of wages occurred): Half Day: \$55.48; Full Day: \$110.96 Amount Allowed: \$ _____

Approved by: _____ Total Amount to be Paid to Payee: \$ _____

Title: _____ Date: _____
 _____ dd / mm / yyyy

NOTICE: Information on this form is collected for the purpose of proceedings with respect to the Workplace Safety and Insurance Act, 1997, S.O. 1997, c. 16, Schedule A. In some cases, it may be necessary for the Tribunal to collect additional information related to the matter. All information is collected pursuant to the Workplace Safety and Insurance Act, 1997, sections 102, 123, 124, 129, 132 and 134. Questions about the collection of information should be directed to the Privacy Coordinator, Workplace Safety and Insurance Appeals Tribunal, 505 University Ave., Toronto, Ontario M5G 2P2 (416) 314-8800.