Workplace Safety and Insurance Appeals Tribunal
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Hearing Expense Claim

Reset Form

Read Practice Direction: Fees and Expenses for additional information.

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 upload receipts): **AMOUNT CLAIMED**

☐ Air ☐ Train ☐ Bus _____ Transportation (A): 0.00

☐ Automobile Kilometres: _____ X 40 cents 0.00

B) HOTEL ACCOMMODATION (Receipt must be uploaded) Accommodation (B): 0.00

C) MEALS (Maximum allowance is $51 per day per person)

Breakfast: No. of meals _____ Amount: _____ ($12 max./day/person) Meal (C): 0.00

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: 0.00

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: _____ (Please type your first and last name)

Date _____ (dd/mm/yyyy) ☐ *By checking this box, I understand and agree that my typewritten name and date represent my legal signature*

**** Please e-file all applicable receipts along with 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 to be utilized in proceedings before the Workplace Safety and Insurance Appeals Tribunal (WSIAT). All information is collected pursuant to the *Workplace Safety and Insurance Act, 1997*, S.O. 1997, c. 16, as amended and will be included in the WSIAT file and provided to the WSIB when the file is returned to the WSIB. This information will only be utilized for workplace safety and insurance purposes. Questions about the collection of information should be directed to the Records Management Coordinator at the WSIAT by calling 416-314-8800 or 1-888-618-8846 (toll-free), or 416-314-1787 (TTY).

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