WORKERS' COMPENSATION COMMISSION

REQUEST TO ENTER APPEARANCE OF COUNSEL FOR EMPLOYER/INSURER

This form is to be used by an attorney only to enter his/her appearance on behalf of an Employer/Insurer. If you are entering your appearance on behalf of a Claimant, please utilize WCC form C24R.

Claim Number: _____ **Date of Accident:** _____

Claimant: _____

Employer: _____

On behalf of:

○ **Employer/Insurer:**

○ **Employer Only:**

○ **Insurer Only:**

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

Name of Counsel: _____

WCC Attorney Registration No.: _____

Street Address: _____

City/State/Zip: _____ _____ _____

Telephone: _____ _____

CERTIFICATION OF SERVICE

I HEREBY CERTIFY that on this _____ day of _____, _____, service of the foregoing was made to all parties entitled to service in accordance with COMAR 14.09.01.03.

_____

Signature

CLICK HERE TO CLEAR THE FORM