

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 , 20 , a copy of this Request to Enter Appearance of Counsel for Insurer/Employer was mailed to all parties or their attorneys.

Signature

10 East Baltimore Street • Baltimore, Maryland 21202-1641
410-864-5100 • Email: info@wcc.state.md.us • Web: <http://www.wcc.state.md.us>