



REQUEST TO ENTER APPEARANCE OF COUNSEL

This form is to be used by an attorney only to enter his/her appearance on behalf of a Claimant, SIF, UEF or Healthcare Provider. If you are entering your appearance on behalf of an Employer/Insurer, please use C26R.

WCC Claim Number

Date of Accident

Claimant

Employer

Healthcare Provider

On Behalf of: **Claimant** **SIF** **UEF** **Healthcare Provider**

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

Name of Counsel

WCC Attorney Code/Registration Number:

Address:

City:

State:

Zip Code:

Telephone:

Email:

CERTIFICATION OF SERVICE

I hereby certify that on this day of , 20 , service of the foregoing was made to all parties entitled to service in accordance with COMAR 14.09.01.03.

Attorney Signature