



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:

Name of Counsel:

WCC Attorney Registration No.:

Street Address:

City/State/Zip:

Office Telephone:

Attorney Email:

Attorney Cell Phone:

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