



Permanent Authorization

To: Ohio Bureau of Workers' Compensation
 Employer Services 22nd Floor
 Self-Insured Department 26th Floor

Please mark a box and return to
 30 West Spring Street
 Columbus, OH 43215-2256

FAX – (614) 728-0456

Policy number
Entity
DBA
Address <hr/> <hr/>

NOTE: For this to be a VALID letter, it must be stamped by Employer Services or by the Self-Insured Department for self-insured employers.

This is to certify that effective _____ (Date)

Wickens, Herzer, Panza, Cook & Batista (21152-91)
 (Representative name and Rep. I.D. number)

including its agents or representatives identified to you by them, has been retained to represent us before the Bureau of Workers' Compensation and the Ohio Industrial Commission in matters pertaining to our participation in the Workers' Compensation Fund according to the type of representation below. Please check the type of representation desired. See description of representatives on side 2.

v	Type of Authorized Representative
	Employer Risk/Claim Representative (ERC)
	Risk Management Representative (RISK)
v	Claim Management Representative (CLM)

This authorization supersedes all permanent authorizations on file for the type of representation indicated above.

I understand and agree any letters, requests, and actions initiated by a superseded authority will be processed completely.

I understand that this authorization, now being granted, is of a continuous nature from the effective date indicated herein. However, I possess the right to terminate this authorization at any time through written notification to the Employer Services or Self-Insured Department as appropriate.

Telephone number	Fax number	E-mail address	
Print name		Employer signature	Date