## REQUEST FOR EMPLOYER DESIGNEE TO RECEIVE NOTICE OF EMPLOYEE CLAIMS

This form is to be used only for employers to designate a person to receive a copy of each Notice of Employee's Claim (C-30) pursuant to Regulation 14.09.01.23(c)(2). *Please note that this request will apply to all locations with the identical Employer name, regardless of the address. For special circumstances, please contact the Claims Division.* 

Name of Employer:	
Address:	
Telephone Number:	
The above-named employer, pursuant to Regu Notice of Employee's Claim (C-30) filed agai	lation 14.09.01.23(c)(2), requests that a copy of each nst it be sent to:
Name of Designee:	
Address:	
Telephone Number: Requested By: Employer	
Authorized Signature	Date
Title	Telephone Number
Address	
WCC Form H23R (06/15/09)	
WORKERS' COMPENSATION COMMISSION • 10	) East Baltimore Street • Baltimore • Maryland • 21202-1641
(410) 864-5100 • Email: info@wcc.state.md.us • Web: http://www.wcc.state.md.us	