



To: Ohio Bureau of Workers' Compensation
 Employer Services Department, 22nd Floor
 Self-Insured Department, 27th Floor

Please mark a box and return to:
Sheakley UniService, Inc.
One Sheakley Way
Cincinnati, OH 45246
800.877.2053
Fax: 513.326.1094 or toll-free: 866.340.7880

From: Policy number	County
Entity	
DBA	
Address	

Note: For this to be a **valid** letter, the self-insured department for self-insured employers, or the employer services department for all other employers, must stamp it. Being temporary in nature, BWC will not record via computer or retain this authorization. Representative must possess a copy when requesting service relative to the authority granted therein.

This is to certify that Sheakley 370-80 of One Sheakley Way, Cincinnati, OH 45246 including its agents or representatives identified to you by them, has been retained to review and perform studies on certain workers' compensation matters on our behalf.

The limited letter of authority provides access to the following types of information relating to our account:

- (1) Risk files;
- (2) Claim files;
- (3) Merit-rated or non-merit-rated experiences;
- (4) Other associated data.

This authorization does not include the authority to:

- (1) Review protest letters;
- (2) File protest letters;
- (3) File form *Application for Handicap Reimbursement* (CHP-4);
- (4) *Notice of Appeal* (IC-12) or *Application for Permanent Partial Reconsideration* (IC-88);
- (5) File self-insurance applications;
- (6) Represent the employer at hearings;
- (7) Pursue other similar actions on behalf of the employer.

I understand this authorization is limited and temporary in nature and will expire on _____ or automatically nine months from the date received by the employer services or self-insured departments, whichever is appropriate. In either case, the length of authorization will not exceed nine months.

Telephone number	Fax number	E-mail address

Print name	Title	Signature	Date