Send form to DWC and a copy to insurance carrier
Texas Department of Insurance
Division of Workers' Compensation
7551 Metro Center Drive, Suite 100
Austin, Texas 78744

CLAIM # _____

Carrier Claim # _____

NOTICE OF REPRESENTATION OR WITHDRAWAL OF REPRESENTATION

GENERAL CLAIM AND REPRESENTATIVE IDENTIFICATION INFORMATION

Section I. Injured Employee Information

1a. Last Name	1b. First Name	1c. Middle Name	1d. Name Suffix

2. Date of Birth (mm/dd/yyyy)	3. Social Security Number	4a. Phone Area Code	4b. Phone Number	4c. Phone Extension	5. Date of Injury (mm/dd/yyyy)

6a. Street Address	6b. City	6c. State	6d. Zip Code

Section II. Beneficiary Information (if represented person is a beneficiary)

7a. Last Name	7b. First Name	7c. Middle Name	7d. Name Suffix

8. Date of Birth (mm/dd/yyyy)	9. Social Security No. (last 4)	10a. Phone Area Code	10b. Phone Number	10c. Phone Extension	11. Relation of Injured Employee
	XXX-XX-				

12a. Street Address	12b. City	12c. State	12d. Zip Code

Section III. Representative Information

13a. Last Name	13b. First Name	13c. Middle Name	13d. Name Suffix

14a. Street Address	14b. City	14c. State	14d. Zip Code

15. Email Address

16. Firm Name

17. Representative's State Bar #	18. Date of License (mm/dd/yyyy)	19a. Phone Area Code	19b. Phone Number	19c. Phone Extension	20. Fax Number

NOTICE OF REPRESENTATION

NOTE: Both the claimant and the representative must sign and date the Notice of Representation below before the relationship becomes Effective. Send this form to DWC at the address shown above and a copy to the insurance carrier.

I certify that I am representing the interests of the above named claimant's workers' compensation claim for the above date of injury under the Following circumstances: (PLEASE CHECK THE APPROPRIATE BOX)

☐ My representation began on: _____. I am not aware of any other person or attorney representing this injured employee at this time.

☐ My representation began on: _____. I am aware that _____ was previously representing this claimant. I hereby certify I have verified that the previous representative has withdrawn representation for the above referenced claimant.

By signing below, I affirm that I qualify as a representative either as an attorney, or, if other than an attorney, I affirm that I qualify as a non-attorney representative under the Texas Workers' Compensation Act and the Workers' Compensation Rules, and that as a non-attorney representative, no fee or remuneration shall be received by me either directly or indirectly from a claimant.

By signing below the claimant acknowledges the person indicated above will represent the claimant for the above date of injury.

Claimant's Signature	Date Signed	Representative's Signature	Date Signed

NOTICE OF WITHDRAWAL OF REPRESENTATION

NOTE: Either the representative or the claimant may terminate this representation relationship at any time, however, Rule 152.1(e) states," A Client who discharges an attorney does not, by this action, defeat the attorney's right to claim a fee." The party terminating the relationship must sign below and provide a copy to the other party, the insurance carrier, and the DWC field office handling the claim.

By my signature below, I am terminating this representation relationship effective the date indicated below. I will provide a copy of this Representation withdrawal notice to the other party, the insurance carrier, and the DWC filed office handling the claim.

Claimant's Signature	Date Signed	Withdrawing Representative's Signature	Date Signed

INSTRUCTIONS FOR FILING NOTICE OF REPRESENTATION OR WITHDRAWAL OF REPRESENTATION

The Texas Department of Insurance, Division of Workers' Compensation has provided this form to allow customers to use standardized form for reporting their representation of injured employee or beneficiaries or to notify DWC regarding the withdrawal of such representation.

Mail this form to DWC at:

Texas Department of Insurance, Division of Workers' Compensation
7551 Metro Center Drive, Suite 100
Austin, Texas 78744

A copy of this form must also be send to the insurance carrier.

Special Instructions for Certain Requested Information

Block 15 The representative should provides an email address if they have one.

Block 16 If, as a representative, you are associated with a specific firm or organization, please provide that organization's name.

Block 17 Complete this block only if you are an attorney who is licensed by the State Bar of Texas.