CONSENT FOR RELEASE OF INFORMATION

Name: _____

Former Employer(s): _____

_____

_____

I authorize Workplace Safety North (WSN) to release my WSN training records to:

Company Name: _____

Address: _____

City: _____ Province: _____ Postal Code: _____

_____
Signature

_____
Date

Send completed form to:

Workplace Safety North™

Workplace Safety North (WSN)
690 McKeown Avenue
North Bay, ON P1B 7M2
Fax: 705.472.5800
E-mail: info@workplacesafetynorth.ca