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FM040R
G040 Referral to DRDRB

WORKER DETAILS

Date of accident November 22, 2022	WCB claim number 756 5184
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Worker's surname Abu-Yeboah	First name Emmanuel	Initial «No Data Found~Claimant Middle Name»	Date of birth July 09, 1986
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Claim owner name Support Desk CA ICON	Supervisor name Travis	Referral created by Ashley Anderson	Sup to DRB letter date 2026/01/26
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Referring department

Customer Service Legal Services Employer Account Services

Appellant (only select one)

Worker or worker representative Employer or employer representative Third party or interested party

ISSUES AND REFERRAL TYPE

Number of issues being referred: 1

Indicate issue type(s):

- | | | |
|--|---|--|
| <input type="checkbox"/> Additional diagnosis or level of responsibility | <input type="checkbox"/> Non-economic loss payment (NELP) or Permanent partial disability (PPD) | Short-term home assistance (STHA), Home maintenance allowance (HMA), Housekeeping allowance (HKA) or Personal care allowance (PCA) |
| <input type="checkbox"/> Claim acceptance (physical) | <input type="checkbox"/> New evidence | <input type="checkbox"/> Total temporary disability (TTD) |
| <input type="checkbox"/> Claim acceptance (psychological) | <input type="checkbox"/> Obligation to reinstate (OTR) or Duty to cooperate (DTC) | <input type="checkbox"/> Re-employment benefits |
| <input type="checkbox"/> Claim expenses | <input type="checkbox"/> Overpayment | <input checked="" type="checkbox"/> Wage loss calculation (TPD, ELP, TEL) |
| <input type="checkbox"/> Compensation rate | <input type="checkbox"/> Recurrence | <input type="checkbox"/> Wage loss entitlement (TPD, ELP, TEL) |
| <input type="checkbox"/> Cost relief or transfer | | <input type="checkbox"/> Worker status |
| <input type="checkbox"/> Medical aid costs | | |
| <input type="checkbox"/> Other (e.g., employer health benefits, sick benefits, etc.):
» Describe issue(s) | | |

	Date G040 received	Corresponding RFR # in eCO	Date of original decision being appealed	
	2026/01/06	91882	2025/12/03	
	Click to enter date.	» Insert RFR number	Click to enter date.	
	Click to enter date.	» Insert RFR number	Click to enter date.	

RESOLUTION SUMMARY

THIS DOCUMENT MAY BE EXAMINED BY ANY PERSON WITH DIRECT INTEREST IN A CLAIM THAT IS UNDER REVIEW.

Worker's (Surname) Abu-Yeboah	(First name) Emmanuel	(Initial) «No Data Found~Claimant Middle Name»	Claim number 756 5184
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Date of supervisor resolution discussion with appellant: January 19 and 25, 2026
If unsuccessful, date of second attempt: [Click to enter date.](#)

Was contact attempted with the other party or respondent? Yes N/A

What type of hearing does the appellant prefer? Select type of hearing.

REFERRAL REQUIREMENTS

Has new information been submitted since the original decision?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> N/A
If yes, has this information been acknowledged?	<input type="checkbox"/> Yes <input type="checkbox"/> N/A
Have the reasons the appellant feels the decision is incorrect been addressed?	<input checked="" type="checkbox"/> Yes
Are all medical investigations and assessments related to the appeal complete?	<input checked="" type="checkbox"/> Yes
Is the G040 within one year of the decision?	<input checked="" type="checkbox"/> Yes
Has the G040 been converted, if applicable (e.g., LWKR, LREP, AO submission)?	<input type="checkbox"/> Yes

ADDITIONAL DETAILS

Is this a premature return?	<input type="checkbox"/> Yes <input checked="" type="checkbox"/> N/A
Does this appellant have any other active RFRs, on this claim or other claim(s)?	<input type="checkbox"/> Yes
Any considerations DRDRB should be aware of? » insert details	<input type="checkbox"/> Yes
Communication plan in effect? » insert details	<input type="checkbox"/> Yes
Is an interpreter required? » insert language details	<input type="checkbox"/> Yes
Additional referral details or other comments » insert details	