WSCC Workers' Safety & Compensation Commission | ᐃᖅᑲᓇᐃᔭᖅᑎᓄᑦ ᐊᑦᑕᓇᖅᑐᓂᒃ ᐊᒻᒪ ᓇᓪᓕᐅᒃᑯᒫᓂᒃ ᖃᐅᔨᓴᖅᑎᑦ

Worker's Report of Occupational Disease

COMPLETE AND RETURN TO THE ADDRESS ON THE BACK OF THIS FORM. PRINT CLEARLY.

WSCC Claim Number

Name of disease or non-traumatic injury	Employer's Name
	Employer's Mailing Address - (include postal code and phone number)
Last Name	
First Name(s)	
Mailing Address (include postal code)	
	Employer Phone and Fax Number
Phone Number - (include area code)	
Social Insurance Number	
Date of Birth | YY | MM | DD |	

GIVE FULL DETAILS OF YOUR WORK HISTORY. INCOMPLETE INFORMATION CAN DELAY YOUR CLAIM.

IN THE NORTHWEST TERRITORIES/NUNAVUT

Employer's Name, Address (include postal code) and Phone Number	Period From	Period To	Type of Exposure and Occupation
	YEAR	YEAR	
	YEAR	YEAR	
	YEAR	YEAR	

OUTSIDE THE NORTHWEST TERRITORIES/NUNAVUT

Employer's Name, Address (include postal code) and Phone Number	Period From	Period To	Type of Exposure and Occupation
	YEAR	YEAR	
	YEAR	YEAR	

Attach Any Additional Information You Have

COMPLETE AND SIGN THIS FORM BEFORE FORWARDING TO THE WSCC

COMPLETE BOTH SIDES OF THIS FORM

WORKER'S CONSENT

I hereby claim compensation for work-related injuries or disease.

Information Sharing – I understand the WSCC uses the above information about me for the sole purpose of conducting an investigation into this claim. I also understand the WSCC will need to gather more information about my work incident and medical and work history to administer my claim. For that specific purpose only, the WSCC may disclose some personal information to employers, medical personnel and other relevant third parties.

I authorize the WSCC to provide and gather such information from all necessary sources, including hospital and doctors' records, and employer records.

Information Accuracy – I understand incomplete information from me may delay my claim, and untrue information from me is unlawful.

I declare the information above is true and accurate. I understand it may be a criminal offence to make a false claim, or to work and earn income while receiving workers' compensation without telling the WSCC.

DATE	SIGNATURE
DATE	WITNESS

Head Office: Box 8888 • Yellowknife, NT X1A 2R3 • Telephone: (867) 920-3888 • Toll Free: 1-800-661-0792 • Fax: (867) 873-4596 • Toll Free Fax: 1-866-277-3677
or
Box 669 • Iqaluit, NU X0A 0H0 • Telephone: (867) 979-8500 • Toll Free: 1-877-404-4407 • Fax: (867) 979-8531 • Toll Free Fax: 1-866-979-8501
www.wscc.nt.ca • www.wscc.nu.ca

Ce formulaire est disponible en français.
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