

Worker's Report of Noise-Induced Hearing Loss

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

Claim Number

Worker Information

Last Name				Present Employer's Name					
First Name(s)				Employer's Mailing Address (include postal code)					
Mailing Address (include postal code)									
				Employer Phone Number and/or Fax (include area code)					
Phone Number (include area code)									
Social Insurance Number									
Gender	<input type="checkbox"/> M	<input type="checkbox"/> F	<input type="checkbox"/> X	Date of Birth	YY	MM	DD	Present Occupation	If off work, give date of layoff

GIVE FULL PARTICULARS OF YOUR EXPOSURE TO HIGH NOISE LEVELS SHOWING NAMES OF EMPLOYERS WITH DATES OF THE PERIOD OF EMPLOYMENT WITH EACH EMPLOYER. INCOMPLETE INFORMATION WILL DELAY YOUR CLAIM.

IN THE NORTHWEST TERRITORIES/NUNAVUT

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

OUTSIDE THE NORTHWEST TERRITORIES/NUNAVUT

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

Please Attach any Additional Information You May Have

FOR YOUR PROTECTION, COMPLETE, SIGN ON REVERSE AND RETURN THIS REPORT

1. When were you first aware of problems with your hearing? • Did you report this to your employer? • If so, when and to whom did you report?	
2. Have you ever had your hearing tested? • If so, state when and who gave you the test. If available, please provide audiograms (hearing tests).	
3. Have you ever worn a hearing aid? • If yes, state date and place purchased.	
4. Have you ever been exposed to a blast or loud explosion? Please provide details.	
5. Have you, or do you intend to file a claim with any other Board for hearing loss? Please provide details.	
6. Have you been exposed to any loud noises, other than in your occupation, such as hunting, snowmobiling, musical instruments, etc.? Please provide details.	
7. Have you ever had any medical problem associated with hearing loss or ear surgery?	
8. Have you lost any time from work on account of your hearing difficulties? If so, please provide the dates.	YY MM DD to YY MM DD
9. Other remarks. Please add any additional comments you may have that would assist in the adjudication of your claim.	

PLEASE ENSURE THAT BOTH SIDES OF THIS FORM HAVE BEEN COMPLETED IN DETAIL

WORKER'S CONSENT

I hereby claim compensation for Noise-Induced Hearing Loss.

Information Sharing – I understand that the above information about me will be used by the WSCC for the sole purpose of conducting an investigation into this claim. I also understand that the WSCC will need to gather more information about my exposure and medical and work history to administer my claim. For that specific purpose only, some personal information may have to be disclosed to employers, medical personnel and other relevant third parties. For more information please read our *Privacy Statement for Workers* at wscn.nt.ca or wscn.nu.ca.

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 that incomplete information from me may delay my claim, and that 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

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