



**Halifax Office**  
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**Sydney Office**  
 404 Charlotte Street  
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902-563-2444 local  
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## Occupational Noise Hearing Loss

WCB Claim Number:

**Please answer all questions on the following work place hearing loss and work history form. Complete information is necessary to properly adjudicate your claim and avoid delays.**

The WCB may not accept responsibility for hearing aids prescribed before entitlement to benefits has been determined. If you need help completing this form, please call us.

### General Information

Worker's Last Name	First Name	Initial	Date of Birth (dd/mm/yyyy)
Mailing Address:			Postal Code:
Health Card Number: SIN:	Telephone #:	Gender: Male <input type="checkbox"/>	Female <input type="checkbox"/>
Have you ever been awarded benefits for hearing loss from any other WCB or agency (e.g. Veterans' Affairs)? Yes <input type="checkbox"/> No <input type="checkbox"/>			
If yes, provide the name of the agency and decision date:			

### Medical Information

When did you <b>first</b> seek medical attention or advice for your hearing loss? (mm/yyyy) From whom?			
Who have you consulted about your hearing problems? Please provide name, address, phone number and <b>approximate appointment dates</b> :			
Family Doctor	<input type="checkbox"/>	_____	
Specialist (Ears, Nose, Throat)	<input type="checkbox"/>	_____	
Occupational Nurse at your workplace	<input type="checkbox"/>	_____	
Hearing Clinic –Testing	<input type="checkbox"/>	_____	
Other	<input type="checkbox"/>	_____	
When did you <b>first</b> know your loss of hearing was caused by noise exposure in your workplace (mm/yyyy) <b>and who told you?</b>			
Please list any hearing tests you had related to your hearing loss, starting with the most recent.			
<b>Hearing Clinic or Hospital Name:</b>	<b>Address:</b>	<b>Phone:</b>	<b>Date of Treatment:</b>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Do you have ringing or other noise in your ears?	Yes <input type="checkbox"/> No <input type="checkbox"/>
If yes, when did you first notice it? (dd/mm/yyyy)	
How often do you notice it (per day):	
Occasionally	<input type="checkbox"/>
Constantly	<input type="checkbox"/>
Only in quiet	<input type="checkbox"/>
Have you reported it to a health professional/doctor?	Yes <input type="checkbox"/> No <input type="checkbox"/>
If yes, please indicate who you saw and when (mm/yyyy)	

**Employment Information**

Are you still working?	Yes <input type="checkbox"/> No <input type="checkbox"/>
If no, please indicate the date you retired or stopped working:	
Have you ever been self-employed?	Yes <input type="checkbox"/> No <input type="checkbox"/>
If yes, please list your business name, date(s) of self-employment and your Canada Revenue Agency Business Number (BN):	
Did you have special protection from the WCB?	Yes <input type="checkbox"/> No <input type="checkbox"/>
If Yes, provide your special protection number: _____	
If No, did you draw wages from the company?	Yes <input type="checkbox"/> No <input type="checkbox"/>
If Yes, please provide copies of your T4 earnings for the years you drew wages.	

**Medical History**

Have you ever had an ear infection?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Right ear <input type="checkbox"/>	Left ear <input type="checkbox"/>	Both <input type="checkbox"/>
Do you grind your teeth?	Yes <input type="checkbox"/> No <input type="checkbox"/>			
Do your parents, children, brothers, or sisters have hearing loss?	Yes <input type="checkbox"/> No <input type="checkbox"/>	From what age?		
Do you know the cause of their hearing loss?	Yes <input type="checkbox"/> No <input type="checkbox"/>			
Please indicate the cause if you know:				
Do you now wear a hearing aid(s)? If so, for how long?				
Where did you purchase it from?				
List all medications (prescribed or over-the-counter) currently taken				
<b>Name of Medication</b>	<b>Why are you taking it?</b>	<b>How Long?</b>		
_____	_____	_____		
_____	_____	_____		
_____	_____	_____		
_____	_____	_____		
_____	_____	_____		

**Please check appropriate boxes**

Have you ever had any of the following?					When?
Ear surgery	Right ear <input type="checkbox"/>	Left ear <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____
Ear Injury	Right ear <input type="checkbox"/>	Left ear <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____
Ear Infection	Right ear <input type="checkbox"/>	Left ear <input type="checkbox"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____
Serious head injury			Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____
Stroke			Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____
Diabetes			Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____
Chemotherapy/radiation treatment			Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____
Meningitis			Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____
Heart Disease/heart attack			Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____

**Recreational Noise History**

Have you ever been exposed to any firearms <b>outside</b> of your work? Yes <input type="checkbox"/> No <input type="checkbox"/>					
If yes, please check all types of firearms used:					
Rifle	<input type="checkbox"/>	Number of years _____	Shoulder shot from	Right <input type="checkbox"/>	Left <input type="checkbox"/>
Shotgun	<input type="checkbox"/>	Number of years _____	Shoulder shot from	Right <input type="checkbox"/>	Left <input type="checkbox"/>
Handgun	<input type="checkbox"/>	Number of years _____			

Have you ever been exposed to any of the following <b>outside</b> of your work?			When?
Power tools	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____
Outboard boat engine	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____
Chain saw	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____
Small/propeller airplane	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____
Motorcycle	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____
Car racing	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____
Loud or amplified music	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____
Farm machinery	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____
Heavy equipment	Yes <input type="checkbox"/>	No <input type="checkbox"/>	_____



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WCB Claim Number:

## Declaration and Consent

I declare that all of the information found on this form is true and correct, and I elect to claim compensation for the aforementioned condition. This declaration is my authority to the WCB to obtain information from any source, including reports of and from all physicians or hospitals, and all or any records pertaining to my case history, examination and treatment.

\_\_\_\_\_  
Name of Worker – Please print

\_\_\_\_\_  
Signature of Worker

\_\_\_\_\_  
Date (DD,MM,YY)

## Representative

I authorize the WCB to provide any information related to this claim to \_\_\_\_\_,  
Name of Representative

who is my \_\_\_\_\_. I designate this person to speak/act on my behalf.  
Relationship to Worker

\_\_\_\_\_  
Signature of Worker

\_\_\_\_\_  
Date (DD,MM,YY)

## Armed Forces Information:

If you were in the Armed Forces, please provide the following information: Service # \_\_\_\_\_

Service Branch \_\_\_\_\_

Period Served: From: \_\_\_\_\_ To: \_\_\_\_\_

# Occupational Work History

WCB Claim Number: \_\_\_\_\_

**Important: This information is critical to your claim and must be filled out completely. If you require any assistance please contact us.**

**Please list all the places you have worked both inside and outside of Nova Scotia, starting with your current or most recent employer.**

Employer's Complete Name	Employer Site <u>Where You Worked</u>		Employment Period		What Type of Work?	Type & Length of Exposure i.e. Noise etc.
	Province	Employer Address	From (MM/YY)	To (MM/YY)		

Signature of Worker \_\_\_\_\_

Date (DD,MM,YY) \_\_\_\_\_