WORK SAFE. FOR LIFE.
WORKERS' COMPENSATION BOARD OF NOVA SCOTIA

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Firefighter Cancer Claim

FCC:09/2017

_____ Claim # _____

IMPORTANT MESSAGE TO THE FIREFIGHTER

Please complete this form if you have been employed, or volunteered, at a fire department which has been covered by Workers' Compensation Insurance during any period of your employment.

The following are the types of cancer (primary site) covered by the *Firefighters' Compensation Act* and the minimum employment/volunteer periods required for each type. If you are unsure of the primary site of your cancer, contact your doctor.

Brain .....10 years	Colon .....20 years	Non-Hodgkin's Lymphoma ..... 20 years
Bladder .....15 years	Kidney .....20 years	Leukemia ..... 5 years

This cancer must have been diagnosed on or after January 1, 1993 in order to qualify under the *Firefighters' Compensation Act*.

PERSONAL INFORMATION (Please Print)

Last Name: _____ First Name and Initial: _____ Date of Birth: D___M___Y_____

Address: _____ SIN: ____/____/ _____

_____

Postal Code: _____ Telephone #: _____ Male / Female _____ NS Health Card #: _____

EMPLOYMENT INFORMATION

1 Are you a full-time or volunteer firefighter? [ ] Full-time [ ] Volunteer

2 Are you currently employed? [ ] Yes [ ] No If retired, please give date of retirement. D_____M_____Y_____

If currently employed, where: _____

3 When did you first start working/volunteering as a firefighter? D_____M_____Y_____

Total number of years as a firefighter: _____Years

4 Please provide information about your position(s) **as a firefighter**, starting with the most recent. Also, please have the Fire Chief or Deputy Chief of each department confirm your information. Use one section for each department you belonged to.

A **Fire Department:** _____ Paid or Volunteer? [ ] Paid [ ] Volunteer

Fire Chief/Deputy: _____ Tel #: _____

Employment Period: From _____ To _____

Main Duties: _____

_____

_____

i. Did this department have Workers' Compensation Insurance coverage at any time during your employment period? [ ] Yes [ ] No [ ] Unknown

ii. Did you attend a fire scene(s), including training, during this period? [ ] Yes [ ] No

iii. If you are a **volunteer**, did you participate in at least 20% of all activities of the fire department each year? [ ] Yes [ ] No

I confirm the above information is correct.

Fire Chief/Deputy: _____ Date: _____

EMPLOYMENT INFORMATION (continued)

B **Fire Department:** _____ Paid or Volunteer? [ ] Paid [ ] Volunteer

Fire Chief/Deputy: _____ Tel #: _____

Employment Period: From _____ To _____

Main Duties: _____

_____

_____

i. Did this department have Workers' Compensation Insurance coverage at any time during your employment period? [ ] Yes [ ] No [ ] Unknown

ii. Did you attend a fire scene(s), including training, during this period? [ ] Yes [ ] No

iii. If you are a **volunteer**, did you participate in at least 20% of all activities of the fire department each year? [ ] Yes [ ] No

I confirm the above information is correct.

Fire Chief/Deputy: _____ Date: _____

5 Please provide the name(s) of other employment, if any, during your volunteer firefighting period.

Employer Name	Phone Number	Length of Service (approx # of years)	Toxic Exposure (Yes or No)

6 Have you had any other claims with the WCB Nova Scotia? [ ] Yes [ ] No

If yes, please list claim number(s): _____

7 Have you been awarded benefits for your cancer from a WCB outside Nova Scotia? [ ] Yes [ ] No

If yes, please list the province(s) from which you receive benefits: _____

8 Please add any additional comments related to the employment information above.

_____

_____

_____

_____

_____

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_____

_____

_____

_____

MUST BE COMPLETED ON EACH PAGE

SIN:_____/_____/_____

MEDICAL INFORMATION

Please attach any medical reports you have that pertain to your cancer.

9 Please indicate your diagnosed cancer:

[ ] Brain Cancer [ ] Bladder Cancer [ ] Kidney Cancer
[ ] Colon Cancer [ ] Non-Hodgkin's Lymphoma [ ] Leukemia

What date were you diagnosed with this cancer? D_____M_____Y_____

10 If you have been unable to work due to your medical condition, what is the date last worked? D_____M_____Y_____

11 When did you first receive medical treatment for this condition? D_____M_____Y_____
Who treated you?

Name of Treating Physician | Address | Telephone

12 Is the physician noted in Question 11 your family doctor? [ ] Yes [ ] No
If no, please provide the name and telephone number of your family doctor:

Name of Family Physician | Address | Telephone

13 Please list any physicians and medical treatment or tests you have had related to your cancer. Please start with the most recent, and attach additional paper, if necessary.

Physician's Name:_____ Telephone: _____
Address:_____ Date of treatment:_____

Type of Treatment (ie. CT Scan, chemotherapy, etc.)

Physician's Name:_____ Telephone: _____
Address:_____ Date of treatment:_____

Type of Treatment (ie. CT scan, chemotherapy, etc.)

DECLARATION AND CONSENT

I declare that all the information provided by me is true and correct to the best of my knowledge.

I consent to the WCB obtaining and distributing any information from MSI/Maritime Medical Care Inc., physicians, health-care professionals, governments, and all or any records pertaining to my current or prior medical history, examinations, treatments and income that the WCB determines is necessary to process this claim.

Firefighter's Signature | Telephone | Date (D/M/Y)