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

Halifax Office
5668 South Street
PO Box 1150
Halifax, NS B3J 2Y2
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404 Charlotte Street, Suite 200
Sydney, NS B1P 1E2
Toll Free: 1-800-880-0003
Phone: 902-563-2444
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Occupational Noise Hearing Loss

WCB Claim Number

Please answer all questions on the following workplace 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 ☐	Female ☐

Have you ever been awarded benefits for hearing loss from any other WCB or agency (e.g. Veterans' Affairs)? Yes ☐ No ☐

If yes, provide the name of the agency and decision date:

Medical Information

When did you **first** 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 **approximate appointment dates:**

Family Doctor ☐ _____

Specialist (Ears, Nose, Throat) ☐ _____

Occupational Nurse at your workplace ☐ _____

Hearing Clinic –Testing ☐ _____

Other ☐ _____

When did you **first** know your loss of hearing was caused by noise exposure in your workplace (mm/yyyy) **and who told you**?

Please list any hearing tests you had related to your hearing loss, starting with the most recent.

Hearing Clinic or Hospital Name:	**Address:**	**Phone:**	**Date of Treatment:**

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

Employment Information

Are you still working? If no, please indicate the date you retired or stopped working:	Yes ☐ No ☐
Have you ever been self-employed?	Yes ☐ No ☐
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? If Yes, provide your special protection number:_____ If No, did you draw wages from the company? If Yes, please provide copies of your T4 earnings for the years you drew wages.	Yes ☐ No ☐ Yes ☐ No ☐

Medical History

Have you ever had an ear infection?	Yes ☐	No ☐	Right ear ☐	Left ear ☐	Both ☐
Do you grind your teeth?	Yes ☐	No ☐			
Do your parents, children, brothers, or sisters have hearing loss?	Yes ☐	No ☐	From what age?		
Do you know the cause of their hearing loss? Please indicate the cause if you know:	Yes ☐	No ☐			
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

Name of Medication	Why are you taking it?	How Long?

Please check appropriate boxes

Have you ever had any of the following?					When?
Ear surgery	Right ear ☐	Left ear ☐	Yes ☐	No ☐	
Ear injury	Right ear ☐	Left ear ☐	Yes ☐	No ☐	
Ear infection	Right ear ☐	Left ear ☐	Yes ☐	No ☐	
Serious head injury			Yes ☐	No ☐	
Stroke			Yes ☐	No ☐	
Diabetes			Yes ☐	No ☐	
Chemotherapy/radiation treatment			Yes ☐	No ☐	
Meningitis			Yes ☐	No ☐	
Heart disease/heart attack			Yes ☐	No ☐	

Recreational Noise History

Have you ever been exposed to any firearms **outside** of your work? Yes ☐ No ☐

If yes, please check all types of firearms used:

Rifle ☐	Number of years _____	Shoulder shot from	Right ☐	Left ☐
Shotgun ☐	Number of years _____	Shoulder shot from	Right ☐	Left ☐
Handgun ☐	Number of years _____			

Have you ever been exposed to any of the following **outside** of your work?			When?
Power tools	Yes ☐	No ☐	
Outboard boat engine	Yes ☐	No ☐	
Chain saw	Yes ☐	No ☐	
Small/propeller airplane	Yes ☐	No ☐	
Motorcycle	Yes ☐	No ☐	
Car racing	Yes ☐	No ☐	
Loud or amplified music	Yes ☐	No ☐	
Farm machinery	Yes ☐	No ☐	
Heavy equipment	Yes ☐	No ☐	

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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: _____

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Occupational Work History

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 Where You Worked		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) _____