

Worker's Report Occupational Noise Induced Hearing Loss

Claim No.	Desk	Allocation No.
Injury		
Date of Injury		
Employer		
To enquire, contact () For toll free number, check local directory		

Home address and postal code if different from above.

Date of Birth (dd/mmm/yyyy)	Social Insurance No.	Miner's Certificate No. or Payroll No.	Language Spoken if Not English
Was the change in your hearing gradual? <input type="checkbox"/> Yes <input type="checkbox"/> No		Does your hearing change from day to day? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Are you bothered by ringing in your ears? <input type="checkbox"/> Yes <input type="checkbox"/> No		Do you have a hearing aid? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Exam Date (dd/mmm/yyyy)	Name and address of Ear, Nose and Throat Specialist		
Have you had your hearing tested? <input type="checkbox"/> Yes <input type="checkbox"/> No	Name and address of Audiologist		
Do you or have you ever used noisy machinery, equipment or firearms outside of work? <input type="checkbox"/> Yes <input type="checkbox"/> No	What Type?		Frequency
Of all the noisy jobs you may have had, which do you feel is the most responsible for your hearing loss?	Name and address of your current employer (if applicable)		
Do you work in a posted noise level area? <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes , what is the decibel level posted?		
Provide names and addresses of two co-workers who can confirm your noise exposure at this place of employment.			
Name		Address	
Name		Address	
Do you still work in hazardous noise conditions? <input type="checkbox"/> Yes <input type="checkbox"/> No	If retired, provide retirement date.	(dd/mmm/yyyy)	Are you unemployed? <input type="checkbox"/> Yes <input type="checkbox"/> No

Please provide your entire work history.					Claim Number			
Start with your first employer first and continue to your most recent employer. Please be as detailed as possible.								
Employer's Name, Address & Province	Employment Dates (dd/mm/yyyy)		Occupation	Equipment Used	Exposure Hours/Day	Ear Protection?	Plant Area	Is Employer Still In Business?
	From	To						
						<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
						<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
						<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
						<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
						<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
						<input type="checkbox"/> Yes <input type="checkbox"/> No		<input type="checkbox"/> Yes <input type="checkbox"/> No
Please provide the name of your union (if member)			Local	Contact Person		Telephone No.		
<p>Sometimes an employer may request the WSIB to disclose a social insurance number in order to locate records to confirm past employment. Would you consent to allowing the WSIB to disclose your social insurance number for the purpose of confirming your past employment.</p> <p>I consent to allowing WSIB to disclose my social insurance number for the purpose of confirming my past employment.</p> <p>Signature _____ Date (dd/mm/yyyy) _____</p>								
<p>I declare all the above information is true and correct. By signing below, I am claiming benefits under the Workplace Safety and Insurance Act, 1997, for a work-related disease (hearing loss). I authorize any health professional who treats me to give me, my employer and the Workplace Safety and Insurance Board, information about my functional abilities with respect to hearing on the WSIB Functional Abilities Form for Timely Return to Work.</p> <p>Signature _____ Date (dd/mm/yyyy) _____ Telephone No. _____</p>								
<p>Personal information about you will be collected throughout your claim under the authority of the Freedom of Information and Protection of Privacy Act and will be used to administer the Workplace Safety and Insurance Act, 1997, your claim and programs of the Board. Medical and non-medical information is collected from health care providers, vocational agencies, labour market service providers, employers, witnesses, and others as required. Your Social Insurance Number is used to register claims, identify workers and to issue income tax receipts and is collected under the authority of the Income Tax Act. Information may only be disclosed to the employer, external medical, vocational, and safety agencies, external payment and service providers, researchers, and others as authorized by the Workplace Safety and Insurance Act and the Freedom of Information and Protection of Privacy Act. Your name and telephone number may be disclosed to third party researchers conducting satisfaction surveys and focus groups. Questions should be directed to the decision maker responsible for your file or toll free at 1-800-387-5540.</p>								

You must give a copy of this form to the employer who you worked for most recently in work associated with this disease