

Please PRINT in black ink



Claim Number
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**A. Worker Information**

Last Name		First Name	
Address (number, street, apt., suite, unit)			
City/Town		Province	Postal Code
Telephone			
Date of Birth	dd mmm yyyy	Social Insurance Number	Miner's Certificate No. or Payroll No.
		Language Spoken if Not English	
<b>1.</b> When did you first notice loss of hearing?  Date (dd/mmm/yyyy) _____  When did you first seek medical attention for your hearing loss?  Date (dd/mmm/yyyy) _____		Was the change in your hearing <input type="checkbox"/> gradual or <input type="checkbox"/> sudden?  Are you bothered by ringing in your ears? <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>2.</b> Do you have a hearing aid? <input type="checkbox"/> Yes <input type="checkbox"/> No  Have you ever been assessed by an Ear, Nose and Throat specialist (ENT)? <input type="checkbox"/> Yes <input type="checkbox"/> No Date (dd/mmm/yyyy) _____  Have you ever had your hearing tested? <input type="checkbox"/> Yes <input type="checkbox"/> No Date (dd/mmm/yyyy) _____		If <b>Yes</b> , please provide the name, address and phone number of the Ear, Nose and Throat Specialist  _____  If <b>Yes</b> , please provide the name, address and phone number of the Clinic.  _____	
<b>3.</b> Are you currently employed? <input type="checkbox"/> Yes <input type="checkbox"/> No  Do you still work in hazardous noise conditions? <input type="checkbox"/> Yes <input type="checkbox"/> No  Have you ever worked in an area where decibel (db) levels were posted? <input type="checkbox"/> Yes <input type="checkbox"/> No		If <b>Yes</b> , please provide the name, address and phone number of your Employer.  _____  If <b>Yes</b> , please provide the name, address and phone number of the Employer.  _____  If <b>Yes</b> , please provide the years worked _____ and decibel level _____	
<b>4.</b> Are you retired? <input type="checkbox"/> Yes <input type="checkbox"/> No  Do you or have you ever used noisy machinery, equipment or firearms outside work? <input type="checkbox"/> Yes <input type="checkbox"/> No		If retired, please provide retirement date. Date (dd/mmm/yyyy) _____  If <b>Yes</b> , what type? _____ If <b>Yes</b> , frequency. _____	
<b>5.</b> Have you ever been self employed? <input type="checkbox"/> Yes <input type="checkbox"/> No  If <b>Yes</b> , did you have personal coverage/optional insurance through WSIB? <input type="checkbox"/> Yes <input type="checkbox"/> No		If <b>Yes</b> , please provide the name, address of the company.  _____  Please provide the dates you were self-employed at your company. Start Date (dd/mmm/yyyy) _____ End Date (dd/mmm/yyyy) _____	

**B. Provide names of two co-workers who can confirm your noise exposure in employment.**

Name	Employer	Position
Name	Employer	Position

**C. Please provide your entire work history.**

Start with your most recent employer first and continue to your oldest employer. Please be as detailed as possible. You may add another page if necessary.



Employer's Name, Address & Province	Employment Dates (dd/mmm/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.	

**D. Declaration and Consent**

- I am claiming benefits under the *Workplace Safety and Insurance Act, 1997*, for a work-related injury/illness; and
- I authorize any health professional who treats me to provide me, my employer and the WSIB with information about my functional abilities on the WSIB's "Functional Abilities Form for Planning Early and Safe Return to Work"; and
- I consent to allowing the WSIB to disclose my Social Insurance Number to my previous employers, if necessary, for the purpose of confirming my past employment.
- I declare all of the above information is true and correct.

By signing below, I agree with all of the above statements.

Signature	Date Signed (dd/mm/yy)
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**The Workplace Safety and Insurance Act requires you to give a copy of this form to the last employer where you worked in the process or exposures that may have caused your current illness.**

**E. Freedom of Information and Protection of Privacy Provisions**

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.

A more detailed Privacy Statement for workers may be found at [www.wsib.on.ca](http://www.wsib.on.ca) or by calling toll free at **1-800-387-0750**.