print reset save

wsib cspaat ONTARIO
Workplace Safety & Insurance Board
Commission de la sécurité professionnelle et de l'assurance contre les accidents du travail

200 Front Street West
Toronto ON M5V 3J1
Toll-Free: 1-800-387-0750

Worker's Report Occupational Noise Induced Hearing Loss

Please PRINT in black ink

OD start > Claim Number

A. Worker Information

Last Name	First Name
Sahu	Manas

Address (number, street, apt., suite, unit)

City/Town	Province	Postal Code	Telephone
	ON		

Date of Birth (dd mmm yyyy)	Social Insurance Number	Miner's Certificate No. or Payroll No.	Language Spoken if Not English

1. When did you first notice loss of hearing? Date (dd/mmm/yyyy)

Was the change in your hearing ☐ gradual or ☐ sudden?

When did you first seek medical attention for your hearing loss? Date (dd/mmm/yyyy)

Are you bothered by ringing in your ears? ☐ Yes ☐ No

2. Do you have a hearing aid? ☐ Yes ☐ No

Have you ever been assessed by an Ear, Nose and Throat specialist (ENT)? ☐ Yes ☐ No

If **Yes**, please provide the name, address and phone number of the Ear, Nose and Throat Specialist

Date (dd/mmm/yyyy)

Have you ever had your hearing tested? ☐ Yes ☐ No

If **Yes**, please provide the name, address and phone number of the Clinic.

Date (dd/mmm/yyyy)

3. Are you currently employed? ☐ Yes ☐ No

If **Yes**, please provide the name, address and phone number of your Employer.

Do you still work in hazardous noise conditions? ☐ Yes ☐ No

Have you ever worked in an area where decibel (db) levels were posted? ☐ Yes ☐ No

If **Yes**, please provide the name, address and phone number of the Employer.

If **Yes**, please provide the years worked ..... and decibel level .....

4. Are you retired? ☐ Yes ☐ No

If retired, please provide retirement date. Date (dd/mmm/yyyy)

Do you or have you ever used noisy machinery, equipment or firearms outside work? ☐ Yes ☐ No

If **Yes**, what type?

If **Yes**, frequency.

5. Have you ever been self employed? ☐ Yes ☐ No

If **Yes**, please provide the name, address of the company.

If **Yes**, did you have personal coverage/optional insurance through WSIB? ☐ Yes ☐ No

Please provide the dates you were self-employed at your company.

Start Date Date (dd/mmm/yyyy)

End Date 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.

OD **Claim Number**

Employer's Name, Address & Province	Employment Dates (dd/mmm/yyyy) From	To	Occupation	Equipment Used	Exposure Hours/Day	Ear Protection?	Plant Area	Is Employer Still In Business?
start >						☐ Yes ☐ No		☐ Yes ☐ No
						☐ Yes ☐ No		☐ Yes ☐ No
						☐ Yes ☐ No		☐ Yes ☐ No
						☐ Yes ☐ No		☐ Yes ☐ No
						☐ Yes ☐ No		☐ Yes ☐ No
						☐ Yes ☐ No		☐ Yes ☐ 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 **Type your name and upload, or print and sign before returning to WSIB.**

Date Signed (dd/mm/yy)

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 or by calling toll free at **1-800-387-0750**.

print reset save