Clear Form

Safety Matters @Work
Workers Compensation Board of PEI
wcb.pe.ca

WORKER'S REPORT – NOISE INDUCED HEARING LOSS

Email To: workerservices@wcb.pe.ca
Mail To: PO Box 757, Charlottetown, PE C1A 7L7
Drop Off: 14 Weymouth Street, Charlottetown, PE
Phone: 902-368-5680
Fax: 902-368-5696
Toll Free: 1-800-237-5049

Complete this form to submit a claim for hearing loss that has developed over a period of time. Ex. I have sustained hearing loss resulting from exposure to occupational noise throughout my career. If your hearing loss is as a result of a specific incident, such as an explosion or sudden blast of noise, complete the Workers Report.

Worker Information

Please Print

First Name:	Last Name:		
Mailing Address:			
City:	Province:	Postal Code:	Country:
Provincial Health (PHN) #:		Date of Birth:	
Home Telephone:	Mobile Telephone:	Email:	

Employment Information

Current Employer:	Dept. Name:	Supervisor's Name:
Address:	City:	
Province:	Postal Code:	Telephone:

Exposure Information

Fully describe what caused your hearing loss:

Were there witnesses? ☐ No ☐ Yes: Witness Name: Job Title:

Which ears are affected?
Ears affected: ☐ Left ☐ Right ☐ Both

When did you first notice your symptoms?:

Do you have a buzzing or ringing in your ear(s)?
Left ear: ☐ No ☐ Intermittent ☐ Constant
Right ear: ☐ No ☐ Intermittent ☐ Constant

Did you use hearing protection? ☐ No ☐ Yes, Describe:

Have you been exposed to loud noise (ie. guns, lawn mowers, snowmobiles, chain saws, farm tractor, or other noise) outside of work? ☐ No ☐ Yes, explain:

Medical Information

Have you had a hearing test? ☐ No ☐ Yes, where was it tested & when?	Have you seen any other health care providers for your hearing loss? Please list.

SUBMIT TO THE WORKERS COMPENSATION BOARD WITHIN SIX MONTHS.
PLEASE DO NOT LEAVE THE ORIGINAL FORM WITH YOUR EMPLOYER.

Type of Employment

Work History (starting with the most recent)

Year(s)	Job Title	Employer	Province	Describe the noise you were exposed to	Hours per day/shift

Banking Information

Do you want to add direct deposit information to your file?

◯ No

◯ Yes, provide: Bank Institution Number: _ _ _ Transit Number: _ _ _ _ _ Account Number: _____

DECLARATION - I authorize the WCB to deposit payments the worker is entitled to receive from them into the bank account specified on this form. I understand I must notify the WCB if the bank account information changes or is closed.

Comments

Provide additional information:

Declarations **Please read carefully. Keep a copy of this form for your reference.**

- I solemnly declare that I will notify my employer and my health care providers that I am filing a claim for Workers Compensation; that I will immediately notify the WCB of PEI of any monies received for work done by me and of any changes in my ability to return to employment.
- I hereby consent to the release of information to my employer concerning my functional abilities and limitations. I understand and agree it may be used to assist me to return to employment safely.
- I understand that this will authorize the WCB to obtain or review information from any source whatsoever pertaining to [my/the worker's] situation, including records of physicians, qualified practitioners or hospitals, a copy of records pertaining to examinations, treatment, history, and employment.
- I will notify WCB of any application for or monies received from Long-Term Disability, Canada Pension Disability or from any other potential source of financial benefit as a result of this injury/accident.
- I understand that it is illegal to provide false or misleading information to WCB, its employees or service providers concerning a WCB claim.
- I make this solemn declaration as if it had the same force and effect as if made under oath.

NOTE: To improve its services, the WCB may contract an independent survey company to survey a sample of workers. The WCB does not know which workers will be contacted. If you are contacted, you can decide whether or not you want to take part. The research company does not share your personal responses with the WCB.

_____ _____

Completed by (Name) Date Completed

The information on this form is collected under the authority of section 6 (12) of the *Workers Compensation Act* and section 31 (a) and (c) of the *Freedom of Information and Protection of Privacy Act* for the purposes of administering the compensation claims, determining employer assessment rates and monitoring workplace safety. If you have any questions about this collection of information, please contact WCB FOIPP Coordinator, Workers Compensation Board of PEI, 14 Weymouth Street, PO Box 757, Charlottetown, PE C1A 7L7, 902-368-5680 or toll free at 1-800-237-5049.

THE *WORKERS COMPENSATION ACT* PROVIDES AUTHORITY TO REFER WORKERS AND/OR THEIR FILES TO MEDICAL OR REHABILITATION PERSONNEL.

ARE THERE EXTRA PAGES ADDED? ◯ NO ◯ YES, HOW MANY:

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Email: workerservices@wcb.pe.ca Fax: 902-368-5696 Tel: 902-368-5680 or 1-800-237-5049

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