Application for Hearing Loss Resulting from Exposure to Long-Term Occupational Noise

RESET

You can complete this form digitally or by hand (please print clearly in black ink). Answer all questions and submit the completed form via fax or mail to WorkSafeBC using the contact information on the last page of this form. Ensure you read and sign the last page and include any necessary attachments before submitting the form to WorkSafeBC. Incomplete applications may result in delays in the processing of your claim.

If you'd like to complete this PDF digitally, you must use Adobe Acrobat. If you don't already have Acrobat on your computer, you can **download Adobe Acrobat Reader**, a free app. Please note the form's functionality will not work properly if the form is opened in an internet browser such as Microsoft Edge or Google Chrome. Open the form in Acrobat by going to your Downloads folder and right-clicking on the PDF file. Select Open with > Adobe Acrobat Reader. Be sure to save your completed form before printing and submitting it.

Section A: Worker's information

Worker's last name	First name	Middle initial
Customer care number	WorkSafeBC claim number	
Address line 1	Preferred first name	
City	Province or state	
Phone number (include area code)	Country (if not Canada)	Postal code or ZIP code
Worker's current occupation		
Date of birth (yyyy-mm-dd)	Business phone number	Business extension
Social insurance number	Personal Health Number (BC Services Card/CareCard)	Email address (optional)

Section B: Employer's information

Employer organization's name	Operating location code	Employer's phone number
Mailing address (line 1)	Type of business	City
Country (if not Canada)	Province or state	Postal or ZIP code

Section C: Other claims

Have you had a claim with any other board or agency for hearing loss or any other hearing or ear problems?

☐ Yes ☐ No

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If yes, please provide the claim number(s) and province(s) (or country if outside of Canada)

Section D: History

Do you believe that workplace noise exposure contributed to your hearing loss?

☐ Yes ☐ No

Approximately when were you first aware of problems with your hearing? (yyyy-mm-dd)

Please explain what you consider to be the cause of your hearing loss

What problems do you notice with your hearing?

Are you aware of any additional possible causes of your hearing loss? If yes, please explain

Have you ever had your hearing tested by

An audiologist	☐ Yes	☐ No	Your employer	☐ Yes	☐ No
A hearing aid practitioner	☐ Yes	☐ No	Other (specify)	☐ Yes	☐ No
Your physician	☐ Yes	☐ No			

If you said yes to any above, please provide specific names, addresses, and dates; also, attach copies of the hearing test(s)

Name	Address	Date (yyyy-mm-dd)

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Do you or have you ever worn a hearing aid? ☐ Yes ☐ No	If yes, in which ear(s)? ☐ Left ear ☐ Right ear ☐ Both	

If yes, provide names and addresses of suppliers and dates of purchase

Name	Address	Date (yyyy-mm-dd)

Do you have ringing or other noises in your ear(s)? ☐ Yes ☐ No	If yes, in which ear(s)? ☐ Right ear ☐ Left ear	If yes, when did you first notice it? (yyyy-mm-dd)
Do your parents, children, or siblings have hearing loss? ☐ Yes ☐ No	If yes, specify who	From what age?
Has any member of your family had ear surgery? ☐ Yes ☐ No	If yes, specify who	At what age?

Have you ever had any of the following?				When?
Hearing aid	☐ Right ear	☐ Left ear	☐ No	
Ear infection	☐ Right ear	☐ Left ear	☐ No	
Ear pain	☐ Right ear	☐ Left ear	☐ No	
Ear surgery	☐ Right ear	☐ Left ear	☐ No	
Feeling of fullness in your ear(s)	☐ Right ear	☐ Left ear	☐ No	
Sudden hearing loss	☐ Right ear	☐ Left ear	☐ No	
Serious head injury	☐ Yes		☐ No	
Thyroid problems	☐ Yes		☐ No	
Whiplash	☐ Yes		☐ No	
High blood pressure	☐ Yes		☐ No	
Exposure to sudden, intense noise (e.g., explosion)	☐ Yes		☐ No	
Diabetes	☐ Yes		☐ No	
Heart disease or attack	☐ Yes		☐ No	
Stroke	☐ Yes		☐ No	

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Have you ever had any of the following?			When?
Kidney problems or disease	☐ Yes	☐ No	
Dizziness or balance problems	☐ Yes	☐ No	
Antibiotics by intravenous (IV)	☐ Yes	☐ No	
Serious illness (e.g., cancer, tuberculosis, malaria, meningitis) If yes, what was it?	☐ Yes	☐ No	
Comments			

Section E: Firearm noise history

Have you **ever** been exposed to any firearms **outside of your work**?	☐ Yes	☐ No
If yes, check the reason(s)		
Hunting	☐ Yes	☐ No
Firing range	☐ Yes	☐ No
Target/trap/skeet shooting	☐ Yes	☐ No
Have you been required to be firearm certified for your work?	☐ Yes	☐ No

Check all types of firearms used	Number of years and dates (yyyy-mm-dd)	Shoulder shot from
☐ Rifle		☐ Right ☐ Left
☐ Shotgun		☐ Right ☐ Left
☐ Handgun		

Section F: Employment history

Age you left school	Date you retired, if applicable (yyyy-mm-dd)	Date you last worked in noise (yyyy-mm-dd)

Were you in the military service? ☐ Yes ☐ No	If yes, during what period (yyyy-mm-dd) From to
What was your job in the service?	
Were you exposed to loud noise or gunfire beyond basic training? ☐ Yes ☐ No	
During any of your employment years, were you self-employed? ☐ Yes ☐ No	
If yes, please provide the following information: Company name	WorkSafeBC account number

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Occupation	
Dates (yyyy-mm-dd)	
Are you or have you been **dispatched** through a union? ☐ Yes ☐ No If yes, answer remaining questions in this section. If no, move on to the next section (Employment and military service history).	
Name of union	Length of time you worked through the union (yyyy-mm-dd) From to
Your occupation	
List any jobs you were dispatched to **outside** of B.C. (include locations and time periods of each)	

If you are/were a member of a labour organization, please attach a letter from the union confirming the date you joined the union, the companies you were dispatched to, and the dates you worked for those companies.

Please complete the employment and military service history on the following pages.

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Employment and military service history

1. Please type or print clearly in dark (black) ink.
2. List all employers and military service duties from the time you left school. Show all job categories held and length of time in each.
3. Start with your first employment and proceed to your most recent employment.
4. Please send additional pages if more space is required.
5. Please complete this form even if submitting a Record of Employment from Service Canada, as they may only provide you with the name of your previous employer.
6. Please sign and date the last page. A signature is required to process your application.

Employer's name, city, and province of employment	**From** (yyyy-mm)	**To** (yyyy-mm)	**Industry**	**Occupation and job duties**	**Hazardous sources of noise exposure** (e.g., equipment, machinery, tools, etc.)	**Exposure to noise** (hours/weeks)
1.						
2.						
3.						
4.						

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Employer's name, city, and province of employment	From (yyyy-mm)	To (yyyy-mm)	Industry	Occupation and job duties	Hazardous sources of noise exposure (e.g., equipment, machinery, tools, etc.)	Exposure to noise (hours/weeks)
5.						
6.						
7.						
8.						
9.						
10.						

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Employer's name, city, and province of employment	**From** (yyyy-mm)	**To** (yyyy-mm)	**Industry**	**Occupation and job duties**	**Hazardous sources of noise exposure** (e.g., equipment, machinery, tools, etc.)	**Exposure to noise** (hours/weeks)
11.						
12.						
13.						
14.						
15.						
16.						

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Employer's name, city, and province of employment	**From** (yyyy-mm)	**To** (yyyy-mm)	**Industry**	**Occupation and job duties**	**Hazardous sources of noise exposure** (e.g., equipment, machinery, tools, etc.)	**Exposure to noise** (hours/weeks)
17.						
18.						
19.						
20.						

List all time periods you were not working (do not include vacation)

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Please read carefully: I declare all the information I have given on this report is true and correct, and I elect to claim compensation for the above-mentioned injuries or disease. I understand it is a serious offence to knowingly make a false claim or to work and earn income while receiving workers' compensation benefits without advising WorkSafeBC (the Workers' Compensation Board of B.C.). I authorize WorkSafeBC and the Workers' Compensation Appeal Tribunal to view or obtain a copy of records pertaining to my examination, treatment, history, and employment from any source whatsoever, including records of physicians, qualified practitioners, medical insurers, hospitals, and any employer. I understand the information is collected, used, and disclosed under the authority of the *Workers Compensation Act* and the *Freedom of Information and Protection of Privacy Act*. I acknowledge that WorkSafeBC may obtain and disclose information from my claim to my employer for the purpose of appeal or may disclose such information to others in accordance with the law, including the *Workers Compensation Act* and the *Freedom of Information and Protection of Privacy Act*.

Signature	Date (yyyy-mm-dd)

Claims Call Centre
Phone 604.231.8888
Toll-free 1.888.967.5377
M–F, 8 a.m. to 6 p.m.

Fax
604.233.9777
Toll-free 1.888.922.8807

Mail
WorkSafeBC
PO Box 4700 Stn Terminal
Vancouver BC V6B 1J1

WorkSafeBC collects information on this form for the purposes of administering and enforcing the *Workers Compensation Act*. That Act, along with the *Freedom of Information and Protection of Privacy Act*, constitutes the authority to collect such information. To learn more about the collection of personal information, contact WorkSafeBC's FIPP Office at PO Box 2310 Stn Terminal, Vancouver, BC, V6B 3W5, email **FIPP@worksafebc.com**, or call 604.279.8171.