



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



Please answer all questions and submit the completed form via fax to WorkSafeBC at the number provided on the last page of this form. Ensure you read and sign the last page, and include all attachments before submitting them to WorkSafeBC. Incomplete applications may result in delays in the processing of your claim.

|  |   |  |                         |
|--|---|--|-------------------------|
|  |   | Customer care number                               | WorkSafeBC claim number |
| <b>Section A: Worker's information</b> |   |  |                         |
| Worker's last name                     |   | First name   | Middle initial          |
| Address line 1                         |   | Preferred first name                               |                         |
| Address line 2                         |   | City   | Province/state          |
| Phone number (include area code)       |   | Country (if not Canada)                            | Postal code/zip         |
| Worker's current occupation            |   |  |                         |
| Date of birth (yyyy-mm-dd)             | Gender<br><input type="checkbox"/> Male <input type="checkbox"/> Female | Business phone number (include area code)          | Extension               |
| Social insurance number                |   | Personal health number (BC Services card/CareCard) |                         |

## Section B: Employer's information

|                            |                         |                                  |                 |
|----------------------------|-------------------------|----------------------------------|-----------------|
| Employer organization name | Operating location code | Phone number (include area code) |                 |
| Mailing address (line 1)   | Type of business        | City                             |                 |
| Mailing address (line 2)   | Country (if not Canada) | Province/state                   | Postal code/zip |

## Section C

|   |
|---|
| <p>Have you had a claim with any other board or agency for hearing loss or any other hearing/ear problems?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>If yes, please provide the claim number(s) and province(s) or country outside of Canada</p> |
|---|

## Section D: History

|  |
|--|
| <p>Do you believe that workplace noise exposure contributed to your hearing loss?</p> <p><input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Approximately when were you first aware of problems with your hearing? (yyyy-mm-dd)</p> |
|--|



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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 causes of your hearing loss?

Have you ever had your hearing tested by

|                          |                              |                             |                 |                              |                             |
|--------------------------|------------------------------|-----------------------------|-----------------|------------------------------|-----------------------------|
| Audiologist              | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Your employer   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Hearing aid practitioner | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Other (specify) | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Your physician           | <input type="checkbox"/> Yes | <input type="checkbox"/> 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) |
|------|---------|-------------------|
|      |         |                   |
|      |         |                   |
|      |         |                   |

Do you or have you ever worn a hearing aid?

|                              |                             |        |                                   |                                    |                               |
|------------------------------|-----------------------------|--------|-----------------------------------|------------------------------------|-------------------------------|
| <input type="checkbox"/> Yes | <input type="checkbox"/> No | If yes | <input type="checkbox"/> Left ear | <input type="checkbox"/> Right ear | <input type="checkbox"/> Both |
|------------------------------|-----------------------------|--------|-----------------------------------|------------------------------------|-------------------------------|

If yes, provide names of suppliers and dates of purchase

| Name | Address | Date (yyyy-mm-dd) |
|------|---------|-------------------|
|      |         |                   |
|      |         |                   |

|  |  |  |
|--|--|--|
| Do you have ringing or other noises in your ears?        | If yes, which ear?   | If yes, when did you first notice it? (yyyy-mm-dd) |
| <input type="checkbox"/> Yes <input type="checkbox"/> No | <input type="checkbox"/> Right ear <input type="checkbox"/> Left ear |  |



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|  |                     |                |
|--|---------------------|----------------|
| Do your parents, children, brothers, or sisters have hearing loss?<br><input type="checkbox"/> Yes <input type="checkbox"/> No | If yes, specify who | From what age? |
| Has any member of your family had ear surgery?<br><input type="checkbox"/> Yes <input type="checkbox"/> No                     | If yes, specify who | At what age?   |

| Have you ever had any of the following?                           |  |  | When? |
|---|--|--|-------|
| Hearing aid   | <input type="checkbox"/> Right ear <input type="checkbox"/> Left ear <input type="checkbox"/> No |  |       |
| Ear infection   | <input type="checkbox"/> Right ear <input type="checkbox"/> Left ear <input type="checkbox"/> No |  |       |
| Ear pain  | <input type="checkbox"/> Right ear <input type="checkbox"/> Left ear <input type="checkbox"/> No |  |       |
| Ear surgery   | <input type="checkbox"/> Right ear <input type="checkbox"/> Left ear <input type="checkbox"/> No |  |       |
| Feeling of fullness in your ears                                  | <input type="checkbox"/> Right ear <input type="checkbox"/> Left ear <input type="checkbox"/> No |  |       |
| Sudden changes in hearing loss                                    | <input type="checkbox"/> Yes <input type="checkbox"/> No   |  |       |
| Serious head injury   | <input type="checkbox"/> Yes <input type="checkbox"/> No   |  |       |
| Thyroid problems  | <input type="checkbox"/> Yes <input type="checkbox"/> No   |  |       |
| Whiplash  | <input type="checkbox"/> Yes <input type="checkbox"/> No   |  |       |
| High blood pressure   | <input type="checkbox"/> Yes <input type="checkbox"/> No   |  |       |
| Sudden intense noise (e.g., explosion)                            | <input type="checkbox"/> Yes <input type="checkbox"/> No   |  |       |
| Diabetes  | <input type="checkbox"/> Yes <input type="checkbox"/> No   |  |       |
| Heart disease/attack  | <input type="checkbox"/> Yes <input type="checkbox"/> No   |  |       |
| Stroke  | <input type="checkbox"/> Yes <input type="checkbox"/> No   |  |       |
| Kidney problems or disease  | <input type="checkbox"/> Yes <input type="checkbox"/> No   |  |       |
| Dizziness/balance problems  | <input type="checkbox"/> Yes <input type="checkbox"/> No   |  |       |
| Antibiotics by intravenous (IV)                                   | <input type="checkbox"/> Yes <input type="checkbox"/> No   |  |       |
| Serious illness (e.g., cancer, tuberculosis, malaria, meningitis) | <input type="checkbox"/> Yes <input type="checkbox"/> No   |  |       |
| If yes, what was it and when did you have it?                     |  |  |       |

## Section E: Firearm noise history

|   |                              |                             |
|---|------------------------------|-----------------------------|
| Have you <b>ever</b> been exposed to any firearms <b>outside of your work</b> ? | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Have you been required to be firearm certified for your work?                   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| If yes, was it for: Hunting   | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Firing range  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |
| Target/trap/skeet shooting  | <input type="checkbox"/> Yes | <input type="checkbox"/> No |



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| Check all types of firearms used | Number of years and dates (yyyy-mm-dd) | Shoulder shot from   |
|----------------------------------|--|--|
| <input type="checkbox"/> Rifle   |  | <input type="checkbox"/> Right <input type="checkbox"/> Left |
| <input type="checkbox"/> Shotgun |  | <input type="checkbox"/> Right <input type="checkbox"/> Left |
| <input type="checkbox"/> 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?<br><input type="checkbox"/> Yes <input type="checkbox"/> No                                |  | If yes, during what period (yyyy-mm-dd)<br>From                      to |
| Were you exposed to loud noise or gunfire beyond basic training?<br><input type="checkbox"/> Yes <input type="checkbox"/> No |  |   |
| During any of your employment years, were you self-employed?<br><input type="checkbox"/> Yes <input type="checkbox"/> No     |  |   |
| If yes, please provide the following information:  |  |   |
| Company name   |  | WorkSafeBC account number   |
| Occupation   |  |   |
| Dates (yyyy-mm-dd)   |  |   |
| Are you or have you been <b>dispatched</b> through a union?<br><input type="checkbox"/> Yes <input type="checkbox"/> No      |  |   |
| Name of union  | Length of time you worked through the union (yyyy-mm-dd)<br>From                      to |   |
| Your occupation  |  |   |
| List any jobs you were dispatched to <b>outside</b> 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 (mm-yyyy) | To (mm-yyyy) | 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.  |                |              |          |                           |   |                                 |
| 5.  |                |              |          |                           |   |                                 |



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|---|-------------------|-----------------|----------|---------------------------|--|------------------------------------|
| 6.  |                   |                 |          |                           |  |                                    |
| 7.  |                   |                 |          |                           |  |                                    |
| 8.  |                   |                 |          |                           |  |                                    |
| 9.  |                   |                 |          |                           |  |                                    |
| 10.   |                   |                 |          |                           |  |                                    |
| 11.   |                   |                 |          |                           |  |                                    |
| 12.   |                   |                 |          |                           |  |                                    |



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|---|-------------------|-----------------|----------|---------------------------|--|------------------------------------|
| 13.   |                   |                 |          |                           |  |                                    |
| 14.   |                   |                 |          |                           |  |                                    |
| 15.   |                   |                 |          |                           |  |                                    |
| 16.   |                   |                 |          |                           |  |                                    |
| 17.   |                   |                 |          |                           |  |                                    |
| 18.   |                   |                 |          |                           |  |                                    |
| 19.   |                   |                 |          |                           |  |                                    |



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

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

**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). 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 freedom of information coordinator at PO Box 2310 Stn Terminal, Vancouver BC, V6B 3W5, or call 604.279.8171.

The Workers' Advisers Office is independent and separate from WorkSafeBC and provides free advice and assistance to help injured workers with their claims. They have offices throughout the province and can be contacted at <http://gov.bc.ca/workersadvisers> or by telephone:

|   |   |   |
|---|---|---|
| <b>Lower Mainland</b><br>Phone 604.713.0360<br>Toll-free 1.800.663.4261 | <b>Vancouver Island</b><br>Phone 250.952.4393<br>Toll-free 1.800.661.4066 | <b>Interior</b><br>Phone 250.717.2096<br>Toll-free 1.800.663.6695 |
|---|---|---|