WORK SAFE. FOR LIFE.
WORKERS' COMPENSATION BOARD OF NOVA SCOTIA

Claims and General Information
1-800-870-3331 toll free
902-491-8999 local
902-491-8001 fax

Physician - Assistive Devices Request Form

WCB Claim Number
Health Card Number

A. REQUEST INFORMATION (to be completed by Case Worker)

To:	Fax:	Phone:
From:	Fax:	Phone:
Re:		

B. WORKER INFORMATION (to be completed by Case Worker)

Worker's Last Name	First Name	Initial	Date of Birth (dd/mm/yyyy)

Date of Injury (dd/mm/yyyy):	Compensable Injury	Body Part Injured

C. DEVICE INFORMATION (to be completed by physician; attach additional page if necessary)

Type of Device	☐ New Device ☐ Replacement Device
If prescribing orthotics or footwear, does the worker have a leg length discrepancy? ☐ Yes ☐ No	If yes, please indicate the discrepancy

Please provide rationale and benefit of device in relation to compensable injury. Where necessary, provide medical and/or scientific evidence to support the request.

D. PHYSICIAN INFORMATION (to be completed by physician; please print)

Name and Professional Designation:		WCB ID #:
Signature:	Phone:	Fax: