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

Halifax Office
5668 South Street
PO Box 1150
Halifax, NS B3J 2Y2
Toll Free: 1-800-870-3331
Phone: 902-491-8999
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Sydney Office
404 Charlotte Street, Suite 200
Sydney, NS B1P 1E2
Toll Free: 1-800-880-0003
Phone: 902-563-2444
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Occupational Disease Form

WCB Claim Number:

OCCUPATIONAL DISEASE

Message to Worker
Please complete this form carefully, sign and return it to the Workers' Compensation Board.

To avoid undue delays in the adjudication of your claim, please provide us with as much information as possible.

General Information

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

Mailing Address:	SIN
	Health Card Number
	Gender: Male ☐ Female ☐

Postal Code:	Telephone #:	Marital Status

1 Name of disease or exposure being claimed:

- ☐ Coal Worker's Pneumonoconiosis
- ☐ Automatic Assumption
- ☐ Silicosis
- ☐ Asbestos Exposure
- ☐ Chemical Exposure (Type:_____)
- ☐ Asthma
- ☐ Industrial Bronchitis
- ☐ Cancer (Type:_____)
- ☐ Other (Please Specify:_____)

2 Smoking History:

Smoker ☐ Never ☐ Former ☐

Number of years smoked: _____

Year quit: _____

No. of cigarettes per day: _____

3 Please indicate the major cause of your condition:

- ☐ Coal dust
- ☐ Silica dust
- ☐ Asbestos
- ☐ Fumes, gases, toxins, vapours, dust or chemicals. Please specify: _____
- ☐ Other Please Specify: _____

_____

4 Are you currently employed? Yes ☐ No ☐

If no, please indicate why

_____

_____

If retired, please give date:

D_____ M____ Y _____

5 Have you been awarded any benefits from any other agency (ie. Veterans' Affairs, LTD) for this condition?

Yes ☐ No ☐

If yes, from who:

_____

6 Have you ever been a member of a union?

Yes ☐ No ☐

If yes, please indicate the name, address and telephone number of the union office?

_____

7 When did you first receive medical treatment for this condition? D_____ M ____ Y _____
Who treated you?

Name of Treating Physician | Address | Telephone

8 Is the physician noted in Question 7 your family doctor? Yes ☐ No ☐
If no, please provide the name and telephone number of your family doctor:

Name of Family Physician | Address | Telephone

9 Please list any physicians and medical treatment or tests you have had related to your condition. Please start with your most recent, and attach additional paper if necessary.

A) Physician's Name: _____ Telephone: _____
Address: _____ Date of Treatment: _____
_____

Type of Treatment (ie. Chest x-ray, PFT's CT Scan, chemotherapy, etc)	Name of Hospital:

B) Physician's Name: _____ Telephone: _____
Address: _____ Date of Treatment: _____
_____

Type of Treatment (ie. Chest x-ray, PFT's CT Scan, chemotherapy, etc)	Name of Hospital:

C) Physician's Name: _____ Telephone: _____
Address: _____ Date of Treatment: _____
_____

Type of Treatment (ie. Chest x-ray, PFT's CT Scan, chemotherapy, etc)	Name of Hospital:

D) Physician's Name: _____ Telephone: _____
Address: _____ Date of Treatment: _____
_____

Type of Treatment (ie. Chest x-ray, PFT's CT Scan, chemotherapy, etc)	Name of Hospital:

Declaration and Consent

I declare that all of the information found on this form is true and correct, and I elect to claim compensation for the aforementioned condition. This declaration is my authority to the WCB to obtain information from any source, including reports of and from all physicians or hospitals, and all or any records pertaining to my case history, examination and treatment.

Signature of Worker

Date (DD/MM/YY)

Representative

I authorize the WCB to provide any information related to this claim to_____, who
(Name of Representative)

is my_____. I designate this person to speak/act on my behalf.
(Relationship to Worker)

Signature of Worker

Date (DD/MM/YY)

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Occupational Work History

Important: This information is critical to your claim and must be filled out completely. If you require any assistance please contact us.

Please list all the places you have worked both inside and outside of Nova Scotia, starting with your current or most recent employer. Please attach any additional pages if necessary.

If you are/were self employed, you must provide copies of your T4 earnings and your WCB Special Protection Number.

Employer's Complete Name	Employer Site Where You Worked		Employment Period		What Type of Work?	Type & Length of Exposure i.e. Dust, Silica, etc.
	Province	Employer Address	From (MM/YY)	To (MM/YY)		