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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 <input type="checkbox"/> Female <input type="checkbox"/>	
Postal Code:	Telephone #:	Marital Status	

#### 1 Name of disease or exposure being claimed:

- Coal Worker's Pneumoconiosis
- 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)

## 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 & your WCB Special Protection Number**

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