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

WCB Nova Scotia
PO Box 1150
Halifax, Nova Scotia B3J 2Y2
Toll-free: 1.800.870.3331
Fax: 902.491.8001

Firefighter Cancer Claim

Claim Number:

Visit our website: wcb.ns.ca

PRINT RESET SAVE

Please submit this completed form by fax to **902.491.8001** or mail to:
WCB Nova Scotia, PO Box 1150, 5668 South Street, Halifax, NS B3J 2Y2

CLAIM CRITERIA

Please complete this form if you have been employed, or volunteered, at a WCB Nova Scotia-covered fire department during any period of your employment.

Below are the types of primary site cancer covered by the *Firefighters' Compensation Act*, and the minimum employment/volunteer periods required for each type. If you are unsure of the primary site of your cancer, contact your doctor.
The following types of cancer are covered by the *Act* if diagnosed on or after **January 1, 1993**:

• Brain	10 years	• Kidney	20 years
• Bladder	15 years	• Leukemia	5 years
• Colorectal	20 years	• Non-Hodgkin's Lymphoma	5 years

The following types of cancer are covered by the *Act* if diagnosed on or after **July 1, 2021**:

• Breast	10 years	• Prostate	15 years
• Cervical	10 years	• Penile	15 years
• Esophageal	25 years	• Skin	15 years
• Lung*	15 years	• Testicular	10 years
• Multiple Myeloma	15 years	• Thyroid	15 years
• Ovarian	10 years	• Ureter	15 years
• Pancreatic	15 years		

*in a person who has not smoked tobacco products for a minimum of 10 years immediately before the date of the initial diagnosis or smoked fewer than 365 tobacco products during their lifetime

Heart attacks that occur within 24 hours after attending an emergency response scene are also covered under the *Act*, if it occurred on or after **July 1, 2021**.

A. Claimant Information

Last Name:			First Name and Initial:	
Address Line 1:				
Address Line 2:				
City:	Province:	Postal Code:	Telephone Number:	☐ Male ☐ Female
Date of Birth: (MM/DD/YYYY) / /	Social Insurance Number:		Nova Scotia Health Card Number:	

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B. Firefighting Employment History

When did you first start working/volunteering as a firefighter?: (MM/DD/YYYY) / /	Total number of years as a firefighter:
Fire Department:	Paid or Volunteer: ☐ Paid ☐ Volunteer
Fire Chief/Deputy:	Telephone Number

Employment/Volunteer Period: (MM/DD/YYYY)
From: / / To / /

Did you attend a fire scene(s), including training, during this period? ☐ Yes ☐ No

If you are a volunteer, did you participate in at least 20% of all activities of the fire department each year? ☐ Yes ☐ No

Fire Chief/Deputy Confirmation:
I confirm the above information is correct.

Fire Chief/Deputy Signature: _____ Date: (MM/DD/YYYY) / /

Business number: ☐☐☐☐☐☐☐☐☐

C. Other Employment Information

1. Are you currently employed? ☐ Yes ☐ No If currently employed, where: _____

If retired, please give date of retirement: (MM/DD/YYYY) / /

2. If you have been unable to work due to your medical condition, what is the date last worked?
(MM/DD/YYYY) / /

3. If you had other employment during the time you were a firefighter, please provide the details below:

Employer Name	Phone Number	Length of Service (approx # of years)	Toxic Exposure (Yes or No)
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

4. Have you been awarded benefits for your cancer from a WCB outside Nova Scotia? ☐ Yes ☐ No

If yes, please list the province(s) from which you receive benefits: _____

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D. Medical Information

1. Please indicate your diagnosis:

☐ Bladder	☐ Esophageal	☐ Multiple Myeloma	☐ Prostate
☐ Brain	☐ Heart Attack	☐ Non-Hodgkin's Lymphoma	☐ Skin
☐ Breast	☐ Kidney	☐ Ovarian	☐ Testicular
☐ Cervical	☐ Leukemia	☐ Pancreatic	☐ Thyroid
☐ Colorectal	☐ Lung	☐ Penile	☐ Ureter

What date were you diagnosed? (MM/DD/YYYY) / /

2. Employer Contact

Name _____

Address _____

3. When did you first receive medical treatment for this condition? (MM/DD/YYYY) / /

Who treated you? Name of Treating Physician _____

Address _____

Telephone Number _____

4. Is the physician noted in Question 3 your family doctor? ☐ Yes ☐ No

If no, please provide the name and telephone number of your family doctor:

Name of Family Doctor _____

Address _____

Telephone Number _____

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

Date of Treatment	Treatment Facility	Type of Treatment (ie. CT Scan, chemotherapy, etc.)

E. Declaration and Consent

I declare that all the information provided by me is true and correct to the best of my knowledge.
I consent to the WCB obtaining and distributing any information from MSI/Maritime Medical Care Inc., physicians, health-care professionals, governments, and all or any records pertaining to my current or prior medical history, examinations, treatments and income that the WCB determines is necessary to process this claim.

Firefighter's Signature	Telephone	Date (MM/DD/YYYY)
		/ /