WCB Nova Scotia
200-137 Venture Run
Dartmouth, NS B3B 0L9

Toll-free: 1-800-870-3331
Fax: 902-491-8001

Occupational Disease Form

Submit online for faster service. Send your completed form via secure message through WCB Online at wcb.ns.ca. You can also return forms by fax or mail.

OCCUPATIONAL DISEASE

WCB Claim Number: _____

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:

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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)

WCB / NOVA SCOTIA

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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)		