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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	20 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	10 years
• Ovarian	10 years	• Ureter	15 years
• Pancreatic	10 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:	<input type="checkbox"/> Male <input type="checkbox"/> Female	
Date of Birth: (MM/DD/YYYY) / /	Social Insurance Number:		Nova Scotia Health Card Number:		

Claim Number: **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: <input type="checkbox"/> Paid <input type="checkbox"/> 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? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If you are a volunteer, did you participate in at least 20% of all activities of the fire department each year? <input type="checkbox"/> Yes <input type="checkbox"/> No			
Fire Chief/Deputy Confirmation: I confirm the above information is correct.			
Fire Chief/Deputy Signature: _____		Date: (MM/DD/YYYY) / /	
Business number: <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>			

C. Other Employment Information

1. Are you currently employed? <input type="checkbox"/> Yes <input type="checkbox"/> 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)
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
4. Have you been awarded benefits for your cancer from a WCB outside Nova Scotia? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, please list the province(s) from which you receive benefits: _____			

Claim Number: _____

D. Medical Information

1. Please indicate your diagnosis:

- | | | | |
|-------------------------------------|---------------------------------------|---|-------------------------------------|
| <input type="checkbox"/> Bladder | <input type="checkbox"/> Esophageal | <input type="checkbox"/> Multiple Myeloma | <input type="checkbox"/> Prostate |
| <input type="checkbox"/> Brain | <input type="checkbox"/> Heart Attack | <input type="checkbox"/> Non-Hodgkin's Lymphoma | <input type="checkbox"/> Skin |
| <input type="checkbox"/> Breast | <input type="checkbox"/> Kidney | <input type="checkbox"/> Ovarian | <input type="checkbox"/> Testicular |
| <input type="checkbox"/> Cervical | <input type="checkbox"/> Leukemia | <input type="checkbox"/> Pancreatic | <input type="checkbox"/> Thyroid |
| <input type="checkbox"/> Colorectal | <input type="checkbox"/> Lung | <input type="checkbox"/> Penile | <input type="checkbox"/> 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) / /
If applicable: I authorize WCB Nova Scotia to share my claim information with the following representative to speak on my behalf:	Representative Name	Relationship