Workers' Compensation Board

Customer Services *Alberta*

9912 - 107 Street
PO Box 2415
Edmonton, Alberta T5J 2S5

Tel: 780-498-3999
Fax: 1-800-661-1993
WCB website: www.wcb.ab.ca

Please find enclosed a Hearing Information Questionnaire and Workers' Employment Record form(s). These documents are needed to apply for a noise-induced hearing loss claim with the Workers' Compensation Board – Alberta (WCB).

Please complete these forms **(ensure you read and sign page 5)** and submit them to the WCB at the address noted above. After receiving the forms, we will open a WCB claim and review it to determine if you are entitled to any WCB benefits.

All sections of both forms should be filled out completely. If all sections are not completed, the forms will be returned to you for completion. If you have any questions, please call the Customer Contact Centre at 780-498-3999 or toll free in Alberta at 1-866-922-9221 then the 7- digit number of the office nearest to you.

If the companies where you were exposed to excessive noise levels are no longer in business, please request the names of all the companies you worked for and the years you worked for them from the Canada Pension Plan. Contributor Clients Services, PO Box 9750 Postal Station T, Ottawa, ON. K1G 4A6. Your request must include your full name, Date of Birth, Social Insurance Number and Your Signature.

If you are/were a member of a labour organization please attach a letter from the union confirming the date you joined the union, the companies you were dispatched to and the dates you worked for these companies.

It is important that both the Hearing Information Questionnaire (form C042) and the Worker's Employment Record (form C131) be submitted to the WCB together. However if you are currently employed in a noisy environment and your employer will be completing the Employer's Information Questionnaire (form C139), you do not need to wait for them to submit their information before sending in your forms.

Workers' Compensation Board
Alberta

C042
HEARING INFORMATION

Box 2415
Edmonton AB T5J 2S5
Tel (780) 498-3999
Fax (780) 427-5863
1-800-661-1993

Please print clearly

WCB Claim Number

Personal Health Number

Claimant's *Surname*	*First Name*	*Initial*
Address *Street*	*City/Town*	*Province*

Postal Code	Telephone Number	Date of Birth *(Year / Month / Day)*	Employee Number
	( )		

Year and month you left school *(Year / Month / Day)*	If retired, date of retirement *(Year / Month / Day)*	If no longer a resident of Alberta, date you left this province *(Year / Month / Day)*

Have you had a claim with any other Board or Agency for hearing loss or any other hearing/ear problems? ☐ Yes ☐ No

If yes, where? _____ when? _____

During any of your employment years, were you self-employed? ☐ Yes ☐ No

If yes, please provide the following information:

Company name: _____

WCB Account Number: _____

Occupation: _____

HEARING LOSS HISTORY

1. Was your change in hearing ☐ Sudden? ☐ Gradual?

2. Have you ever had a blow/injury to your head and/or ears? (e.g. Welding spark, motor vehicle accident, loud noise, explosion, etc.)

   ☐ Yes ☐ No If yes, please supply details of incident:

   Date: _____

   Description: _____

   _____

   _____

   _____

   Names and addresses of doctors and/or facilities where treatment was sought:

Name	Address

   If work related, please supply the name of your employer at the time: _____

3. Did you apply for compensation for the above incident? ☐ Yes ☐ No

   If yes, in which province? _____ Claim Number: _____

4. Did you ever experience any of the following problems?

Dizziness/balance problems ☐ Yes ☐ No If yes, did you receive treatment? ☐ Yes ☐ No

Name of doctor(s)	Address	Date

Pain and/or discharge from ears ☐ Yes ☐ No If yes, did you receive treatment? ☐ Yes ☐ No

Name of doctor(s)	Address	Date

Ear Infection ☐ Yes ☐ No If yes, did you receive treatment? ☐ Yes ☐ No

Name of doctor(s)	Address	Date

Ringing in ears ☐ Yes ☐ No If yes, how many years have you had tinnitus/ringing _____

Which ear does this affect? ☐ Left ☐ Right ☐ Both Is noise ☐ Constant ☐ Intermittent

Please outline how this noise affects your usual activities of daily living, i. e. what activities do you have difficulty performing due to this noise? _____

If you are currently experiencing any of the above problems and have not sought medical treatment, we would advise that you do so. Please notify us of the physician's name and date of appointment.

5. Have you ever had your hearing tested by:

Audiologist ☐ Yes ☐ No

Hearing Aid Practitioner ☐ Yes ☐ No

Your physician? ☐ Yes ☐ No

Your employer? ☐ Yes ☐ No

Other? (Specify) ☐ Yes ☐ No _____

If yes, please provide specific names, addresses and dates, also attach copies of the hearing test.

Name(s)	Address	Date

6. Do you or have you ever worn a hearing aid? ☐ Yes ☐ No

If yes, ☐ LEFT

☐ RIGHT

☐ BOTH

If yes, provide name of supplier and dates of purchase.

Name(s)	Address	Date

MEDICAL HISTORY

1. Is there a history of deafness or ear disease in your family? ☐ Yes ☐ No If yes, please supply details.

Name(s)	Age	Cause

2. Do you have or have you had any medical problems for which you took medication on a regular basis? ☐ Yes ☐ No

   If yes, please supply details.

Condition	Medication	Prescribing Doctor	Date

3. Do you have any congenital or facial deformities? (e.g. cleft palate) ☐ Yes ☐ No

NOISE EXPOSURE

1. Are you ☐ RIGHT HANDED? ☐ LEFT HANDED? ☐ BOTH?
2. Have you ever operated farm machinery? ☐ Yes ☐ No If yes, please specify equipment used and during what years.

Equipment	Years From	Years To	Equipment	Years From	Years To

Was any of the equipment horse-drawn? ☐ Yes ☐ No If yes, please specify equipment used and during what years.

Equipment	Years From	Years To	Equipment	Years From	Years To

Did any of the equipment have cabs? ☐ Yes ☐ No If yes, please specify equipment used and during what years.

Equipment	Years From	Years To	Equipment	Years From	Years To

Did you wear hearing protection? ☐ Yes ☐ No If yes, during what years? _____

What was the size, type (i.e. mixed, dairy) and location of the farm?

Size	Type	Location

3. If you were engaged in farming activities, were you self-employed?

Do you have WCB coverage? ☐ Yes ☐ No If yes, please supply the following information:

Company Name	WCB Account Number

Were you employed by a company or corporation? (e.g. ABC Farms Ltd.) ☐ Yes ☐ No

If yes, please supply the following information

Company Name	Address

4. Do you or did you ever hunt or shoot? ☐ Yes ☐ No

If yes, was this shooting for ☐ Recreation

☐ Armed Forces

☐ Other (Please specify) _____

If yes, please supply the following information regarding shooting:

Gun Used	Calibre	Shots per year	During what years
Rifle			
Shotgun			
Handgun			
Other			

Did you wear hearing protection while gunhandling for:

RECREATION? ☐ Yes ☐ No

ARMED FORCES? ☐ Yes ☐ No

OTHER ☐ Yes ☐ No

5. Have you served in the Armed Forces? ☐ Yes ☐ No If yes, please supply the following information:

Service Number	Years of Service *(YY/MM/DD)*	Occupation	Dates
	From To		From To
			From To
			From To
			From To

If you served in the Canadian Military please complete and return the attached Armed Forces Release on page 6.

Declaration and Consent

I declare that the information provided by me on this questionnaire to be true and correct.

I understand that:

My social insurance number may be disclosed to past/present employers in order to confirm my employment history

WCB-Alberta may collect information that it considers relevant to determine benefit entitlement, including information pre-dating my accident, from any source including physicians, other health care providers, employer(s) and vocational rehabilitation service providers.

This information is collected to determine my entitlement to compensation under the Workers' Compensation Act.

WCB-Alberta may use and disclose the information collected to determine entitlement, to provide services and benefits and, as required or authorized by law. This information may be used and disclosed pursuant to the Workers' Compensation Act and the Freedom of Information and Protection of Privacy Act.

Signature

Date *(yy/mm/dd)*

Social Insurance #:

Signing the above consent enables the Workers' Compensation Board to process your claim.

The personal information on this form is being collected in compliance with sections 33(a) & (c) of the Freedom of Information and Protection of Privacy (FOIP) Act and will be used for the purpose of adjudicating your hearing loss claim. The information will be treated in accordance with the privacy protection provisions of Part 2 of the FOIP Act.

ARMED FORCES RELEASE

When did you serve in the Armed forces. From _____ To _____ (yy/mm/dd)

In what trade? _____ Service number _____

Medical Pension? ☐ Yes ☐ No For hearing / ear related problem? ☐ Yes ☐ No

If you served in the Armed Forces, you may wish to pursue a claim through the Bureau of Pension Advocates at your nearest federal Government Branch. (Consult your telephone book for the address).

In view of your service in the Armed Forces, we will be requesting specific employment information in regards to your hearing loss claim. In order to do so, we must have you sign, date, and return the following Release Form to our office.

To: ATIP and Personnel Records Division
Library and Archives Canada
395 Wellington St.
Ottawa ON K1A 0N4

I hereby authorize the National Personnel Records Centre, Public Archives Canada, to disclose any personal and/or documentary information about me contained in the files held in their custody, to:

Workers' Compensation Board of Alberta
P.O. Box 2415, 9912 - 107 Street
Edmonton AB T5J 2S5

_____ _____

Signature and regimental number of ex-serviceperson Date *(yy/mm/dd)*

C131

WORKER'S EMPLOYMENT RECORD NOISE INDUCED HEARING LOSS CLAIM

Workers' Compensation Board
Alberta

Box 2415
Edmonton AB T5J 2S5
Fax (780) 427-5863
1-800-661-1993

WCB Claim Number

Worker's *Surname* *First Name* *Initial*

Page Of

Please type or print clearly in dark (black) ink.

INSTRUCTIONS

1. List all employers and military service duties from the time you left school. Show all job categories held and length of time in each.

2. In completing this form, start with your first employment and proceed to your most recent employment.

3. Please complete this form even if submitting a record of employment from CPP

Employer's Name, City & Province of employment	Employment From / To Dates (Month/Year)	Occupation Job Duties	Sources of Noise Exposure	Exposure to Noise Hours / Weeks	Hearing Protection Used and Type
1.	From To				
2.	From To				
3.	From To				
4.	From To				
5.	From To				
6.	From To				
7.	From To				
8.	From To				

C131

WORKER'S EMPLOYMENT RECORD NOISE INDUCED HEARING LOSS CLAIM

Workers' Compensation Board
Alberta

Box 2415
Edmonton AB T5J 2S5
Fax (780) 427-5863
1-800-661-1993

WCB Claim Number

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1.	From To				
2.	From To				
3.	From To				
4.	From To				
5.	From To				
6.	From To				
7.	From To				
8.	From To				

Workers' Compensation Board
Alberta

Box 2415
Edmonton AB T5J 2S5
Fax 780-427-5863

C139
EMPLOYER'S INFORMATION QUESTIONNAIRE

To be completed by the employer only

Claim Number:	
Worker's: *(Surname)* *(Given)* *(Initials)*	Date of Birth *(Year / Month / Day)*
Social Insurance #:	Occupation
Company Name (as supplied by worker)	Date of Employment from *(Year / Month / Day)* to *(Year / Month / Day)*

EMPLOYMENT HISTORY

1. Please confirm and/or correct dates of employment, province employed in and occupations as stated above:

FROM *(Year / Month / Day)*	TO *(Year / Month / Day)*	OCCUPATION	PROVINCE

2. We are unable to confirm employment as stated above for one of the following reasons: *(Please check appropriate box)*

☐ We have no personnel files dating back beyond this date: _____

☐ The company has changed ownership as of _____ and you may contact the former owner, _____

at this phone number, (address) _____

☐ We have searched our records and spoken to long time employees. We have been unable to confirm this claimant's employment with us.

☐ Other *(Please explain)* _____

SAFETY PRECAUTIONS

Was hearing protection provided? ☐ Yes ☐ No

Did you have a policy which required or enforced the use of hearing protection? ☐ Yes ☐ No

HEARING ASSESSMENTS *(Check appropriate box and complete.)*

☐ Audiograms have been taken and **all copies are attached.**

☐ Audiograms have been taken and copies can be obtained from: _____

☐ Hearing assessments have not been completed for our employees.

Worker's: *(Surname)*	*(Given)*	*(Initials)*	Claim Number:

HEARING ASSESSMENTS Continued *(Check appropriate box and complete.)*

☐ Any additional comments you wish to provide would be appreciated. e.g. any pre-existing problems, any knowledge of traumatic injury, etc.

NOISE LEVEL READINGS *(Check appropriate box and complete.)*

☐ Noise level readings have been taken and **copies are attached.**

☐ Noise level readings have been taken and you may obtain them from: _____

☐ Noise level readings have not been taken.

☐ List the equipment, tools, machinery, etc. that the worker would have used or would be located near the work area.

We wish to thank you for your time in providing this information.

Name of Company: _____ Telephone Number: _____

Name of Person Completing Form *(Please Print)* _____

Signature: _____ Date: _____

Position: _____