WORKERS' COMPENSATION BOARD
Northwest Territories and Nunavut

Employer's Repetitive Strain Injury Questionnaire

WCB Claim Number

Worker Information

Last Name	First Name

Mailing Address (include postal code)	Community	Telephone (include area code)

Residential Address	Date of Birth	YY	MM	DD	Sex ❑ M ❑ F

Employer's Name	Worker's Occupation

Introduction

A claim for compensation has been received on behalf of your employee for a repetitive injury type. This could be considered a progressive condition, and because no direct injury is involved, we must establish whether or not this is work-related.

1. Briefly describe main functions of this job.

2. Please describe the workplace set up, including the position of any furniture, fixed tools, etc. that the worker uses.

3. Is the workplace hot, cold or normal room temperature?

Hot ❑ Cold ❑ Room Temperature ❑

4. Repetitive tasks in worker's job: *(Specify on grid):*

- **Weight involved with task**
- **Force applied to do task**
- **Right or left hand or both**
- **Hours per day**
- **Continuous hours performed**
- **Frequency/length/number of breaks**
- **Vibratory Tools Used**

Task	Weight	Force	R/L/Both	Hrs/Day	Cont. Hrs.	Breaks	Vibratory Tools
1.							
2.							
3.							
4.							
5.							
6.							
7.							

5. Do any of these movements involve: twisting motion; wringing motion; above shoulder level work; gripping motion?

(Circle and relate to # of task above)

Twisting motion ❑ Wringing motion ❑ Above shoulder level work ❑ Gripping motion ❑

Vibrating tools/equipment ❑ (specify):

Dropping small items ❑ Other: ❑ (specify):

6. Have there been any recent changes in the type or number of tasks the worker performs? If yes, please specify:	
7. Has/had he/she been doing any overtime or extraordinary work? If yes, please specify:	
8. Have there been any changes/ alterations/modifications to the work stations? If yes, when?	
9. How long has the worker had this present job?	
10. When were the symptom(s) first reported to you?	
11. Describe the difficulties worker was having in performing the job?	
12. Are other workers aware of his/her problems at work?	
13. Have you made any accommodations for this worker specifically to assist with this problem? *(Hours, workspace, tools, breaks, etc?)* If yes, describe:	

	Activity	Frequency
14. Are you aware of any personal activities, including sports, hobbies, recreation, fitness or weight training (past or present) that this worker participates in? Type? How often?		
Any additional information?		

This information will help determine if the claim is work related in whole or in part. Your employee is also being requested to fill out a similar form. Please submit a copy of the worker's job description with the completed Repetitive Strain Injury questionnaire.

FOR QUESTIONS, CALL 1-800-661-0792 OR 920-3888.

Thank you.

Signature of Employer: ______________________________ Date: ________________