



# Workers' Report of Whitehand Syndrome

PLEASE COMPLETE AND RETURN TO THE ADDRESS ON THE BOTTOM OF THIS FORM.

PLEASE PRINT CLEARLY									
LAST NAME					PRESENT EMPLOYER'S NAME				
FIRST NAME(S)					EMPLOYER'S MAILING ADDRESS - INCLUDE POSTAL CODE & PHONE NUMBER				
MAILING ADDRESS - INCLUDE POSTAL CODE									
PHONE NUMBER - INCLUDE AREA CODE									
SOCIAL INSURANCE NUMBER					LENGTH OF EMPLOYMENT WITH THIS COMPANY				
DATE OF BIRTH	DAY	MONTH	YEAR	MARITAL STATUS	NO. OF CHILDREN	PRESENT OCCUPATION			IF OFF WORK, GIVE DATE OF LAYOFF

GIVE FULL PARTICULARS OF YOUR WORK HISTORY. INCLUDE NAMES AND ADDRESSES OF EMPLOYERS, PERIOD OF EMPLOYMENT, TYPES OF MACHINERY USED AND LENGTH OF TIME YOU USED THEM. THIS INFORMATION WILL BE CONFIRMED WITH THE LISTED EMPLOYERS. PLEASE REMEMBER THAT INCORRECT INFORMATION WILL DELAY THE ADMINISTRATION OF YOUR CLAIM

IN THE NORTHWEST TERRITORIES				
EMPLOYER'S NAME AND ADDRESS	PERIOD		TYPE OF MACHINERY USED	DAYS PER WEEK AND/OR HOURS PER DAY
	FROM	TO		
	YEAR	YEAR		
	YEAR	YEAR		
	YEAR	YEAR		

OUTSIDE THE NORTHWEST TERRITORIES				
EMPLOYER'S NAME AND ADDRESS	PERIOD		TYPE OF MACHINERY USED	DAYS PER WEEK AND/OR HOURS PER DAY
	FROM	TO		
	YEAR	YEAR		
	YEAR	YEAR		

PLEASE ATTACH ANY ADDITIONAL INFORMATION YOU MAY HAVE.  
PLEASE ENSURE THAT THIS FORM IS COMPLETED AND SIGNED BEFORE FORWARDING TO THE WCB

DATE	SIGNATURE
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or

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