WORKERS' COMPENSATION BOARD OF NOVA SCOTIA

5668 South Street
Post Office Box 1150
Halifax, NS B3J 2Y2
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Toll Free: 1-800-870-3331
Fax: (902) 491-8263

Medical Arts Building
336 Kings Road, Suite 117
Sydney, NS B1S 1A9
Tel: (902) 563-2444
Toll Free: 1-800-880-0003
Fax: (902) 563-0512

Claim No: _____

Firm No: _____ Yr: _____

For WCB use only

Note: Please complete this form carefully, sign and return it to your nearest Workers' Compensation Board office.

OCCUPATIONAL DISEASE

Message to Worker:
Determining eligibility for benefits may take several weeks. To avoid undue delays in the adjudication of your claim, please provide us with as much information as possible. If you have not already done so, please arrange an examination with your physician and have him/her complete the attached Physician's Report. If it is necessary to lose time from work for this examination, any claim for earnings loss must be confirmed by your employer. If you need help completing this form, please call us.

Client's Last Name: _____ Given Names: _____ Date of Birth: D: M: Y:

Address: _____ SIN: _____

NS Health Card #: _____

Sex: ☐ Male ☐ Female

Postal Code: _____ Telephone #: _____ Marital Status: _____

1 Please indicate the condition you are claiming. Have your physician complete the attached report outlining a diagnosis.
- ☐ Pneumoconiosis (Silicosis, Coal Worker's Pneumoconiosis, Asbestosis)
- ☐ Automatic Assumption
- ☐ Industrial Bronchitis
- ☐ Cancer

2 Smoking History:
Smoker ☐ Never ☐ Former ☐ Number of years smoked_____
Year Quit_____ Amount 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:

_____

4 When did you first seek treatment for this condition? D_____ M_____ Y_____

5 Please list any medical treatment or tests you have had related to your condition.

Physician's Full Name _____ Date of treatment: D_____ M_____ Y_____
Address _____ Treatment: _____
Phone #: _____

Physician's Full Name _____ Date of treatment: D_____ M_____ Y_____
Address _____ Treatment: _____
Phone #: _____

6 Are you currently employed? ☐ Yes ☐ No
If yes, name and phone number of employer:

_____

If retired, please give date: D_____ M_____ Y_____

7 Has your physician ordered you off work due to this condition? ☐ Yes ☐ No
If yes, indicate layoff date: D_____ M_____ Y_____

8 Has your condition caused a change in your job or employment status?
☐ Yes ☐ No
If yes, please specify:

_____

9 Have you had any other claims with the WCB? ☐ Yes ☐ No
If yes, please indicate your claim number(s):

_____

10 Have you been awarded a pension by the WCB either by lump sum or continuous payments? ☐ Yes ☐ No
If yes, please indicate your claim number(s):

_____

11 Have you been awarded benefits from any WCB outside Nova Scotia for this condition?
☐ Yes ☐ No
If yes, indicate the province(s) from which you receive benefit(s):

_____

Please complete the other side of this form.

List all the places you have worked, starting with your current or most recent employer. (Use additional paper if necessary.)

Employment in NS Employer	Address	Employment Period From	To	Type of Work – List all jobs for each employer and duration of each job	Type and length of exposure i.e. dust, silica, etc.	Type of protective equipment used i.e. respirator, dust mask, etc.

Employment outside NS Employer	Address	Employment Period From	To	Type of Work – List all jobs for each employer and duration of each job	Type and length of exposure i.e. dust, silica, etc.	Type of protective equipment used i.e. respirator, dust mask, etc.

Have you ever been a member of a union? ☐ Yes ☐ No

If yes, please indicate the name, address and telephone number of union office:

Length of time you worked through the union: From: To:

List any jobs you were dispatched to outside NS (Include locations and employment periods for each):

Job: Location: From: To:

I declare all the above to be true and correct and 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, all or any records pertaining to my case history, examination and treatment.

Signature:

Date:

D M Y