Halifax Office
5668 South St
Post Office Box 1150
Halifax NS B3J 2Y2

902-491-8999 local
1-800-870-3331 toll free
902-491-8001 fax

Sydney Office
Medical Arts Building
336 Kings Road, Suite 117
Sydney NS B1S 1A9

902-563-2444 local
1-800-880-0003 toll free
902-563-0512 fax

Occupational Disease Form

WCB Claim Number:

OCCUPATIONAL DISEASE

Message to Worker
Please complete this form carefully, sign and return it to the Workers' Compensation Board.

To avoid undue delays in the adjudication of your claim, please provide us with as much information as possible.

General Information

Worker's Last Name	First Name	Initial	Date of Birth (dd/mm/yyyy)
Mailing Address:		SIN	
		Health Card Number	
		Gender: Male ☐ Female ☐	
Postal Code:	Telephone #:	Marital Status	

1 Name of disease or exposure being claimed:

- ☐ Silicosis/Coal Worker's Pneumonoconiosis
- ☐ Automatic Assumption
- ☐ Asbestos Exposure
- ☐ Chemical Exposure (Type:____________________)
- ☐ Asthma
- ☐ Industrial Bronchitis
- ☐ Cancer (Type: ____________________________)
- ☐ Other (Please Specify: ______________________)

2 Smoking History:

Smoker ☐ Never ☐ Former ☐

Number of years smoked: ___________

Year quit: ___________

No. 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 Are you currently employed? Yes ☐ No ☐

If no, please indicate why

____

____

If retired, please give date:

D ____ M ____ Y ________

5 Have you been awarded any benefits from any other agency (ie. Veterans' Affairs, LTD) for this condition?

Yes ☐ No ☐

If yes, from who:

____

6 Have you ever been a member of a union?

Yes ☐ No ☐

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

____

7 When did you first receive medical treatment for this condition? D ____ M ____ Y ________
Who treated you?

____

Name of Treating Physician | Address | Telephone

8 Is the physician noted in Question 7 your family doctor? Yes ☐ No ☐
If no, please provide the name and telephone number of your family doctor:

____

Name of Family Physician | Address | Telephone

10 Please list any physicians and medical treatment or tests you have had related to your condition. Please start with your most recent, and attach additional paper if necessary.

A) Physician's Name: ______________________ Telephone: ____________

Address: ______________________ Date of Treatment: ____________

____

Type of Treatment (ie. Chest x-ray, PFT's CT Scan, chemotherapy, etc)

B) Physician's Name: ______________________ Telephone: ____________

Address: ______________________ Date of Treatment: ____________

____

Type of Treatment (ie. Chest x-ray, PFT's CT Scan, chemotherapy, etc)

C) Physician's Name: ______________________ Telephone: ____________

Address: ______________________ Date of Treatment: ____________

____

Type of Treatment (ie. Chest x-ray, PFT's CT Scan, chemotherapy, etc)

D) Physician's Name: ______________________ Telephone: ____________

Address: ______________________ Date of Treatment: ____________

____

Type of Treatment (ie. Chest x-ray, PFT's CT Scan, chemotherapy, etc)

Declaration and Consent

I declare that all of the information found on this form is true and correct, and I 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, and all or any records pertaining to my case history, examination and treatment.

____ ______________________________

Signature of Worker Date (DD,MM,YY)

Representative

I authorize the WCB to provide any information related to this claim to ________________________________, who
(Name of Representative)

is my ______________________________. I designate this person to speak/act on my behalf.
(Relationship to Worker)

____ ______________________________

Signature of Representative Date (DD,MM,YY)

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Workers' Compensation Board of Nova Scotia

Occupational Work History

Important: This information is critical to your claim and must be filled out completely. If you require any assistance please contact us.

Please list all the places you have worked both inside and outside of Nova Scotia, starting with your current or most recent employer. Please attach any additional pages if necessary.

If you are/were self employed – You must provide copies of your T4 earnings & your WCB Special Protection Number

Employer's Complete Name	Employer Site Where You Worked		Employment Period		What Type of Work?	Type & Length of Exposure i.e. Dust, Silica, etc.
	Province	Employer Address	From (MM/YY)	To (MM/YY)		