WORKERS' COMPENSATION BOARD OF BC

PLEASE SEND THIS REPORT TO THE OFFICE COVERING WORKER'S WORKPLACE AREA. PLEASE NOTE: FACSIMILE (FAX) COPIES ARE ACCEPTABLE AT ALL WCB OFFICES IN B.C.

APPLICATION OF WORKER Asbestos-Related Disease

Please answer all questions and complete this report in ink. Incomplete applications may have to be returned resulting in some delay in the processing of your claim. Please ensure that this report is signed and mailed to the WCB office serving your workplace area.

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WORKER'S LAST NAME *(please print)* *Mr. Ms. Mrs. Miss*			Employer's name *(last employment where exposed to asbestos)*	
First name(s)		Middle initial	Mailing address	
Mailing address			City	Postal code
City		Postal code	Location of plant or project where exposure occurred	Postal code
Telephone number	Social insurance number	Date of birth *Month Day Year*	Type of business	
Weight	Height	Marital status ❒ Married ❒ Single ❒ Other	Worker's occupation	Employer's telephone number

1. Give date of diagnosis of asbestos *Month Day Year*	If you are retired or disabled, give the date you last worked *Month Day Year*
2. On what date did you first become a resident of BC? *Month Day Year*	
3. When were you first employed in BC, where you first had exposure to asbestos? *(on pages 2 and 3 of this form, please give names and addresses of all employers, dates, duration, and type of work done with each)*	
4. Have you worked outside of BC? ❒ Yes ❒ No	If yes, on pages 2 and 3 of this form, please give names and addresses of all employers, dates, duration, and type of work done with each.
5. Have you ever suffered from tuberculsosis? ❒ Yes ❒ No	If yes, when?
6. Have you every previously made a claim with another WCB or agency for an asbestos-related condition? ❒ Yes ❒ No	If yes, when and where?
7. Are you in receipt of or entitled to any military pension, workers' compensation, or other pension, insurance, or benefit? ❒ Yes ❒ No	If yes, what?
8. Please provide confirmation of your gross earnings in the last three years that you worked *(T4s, income tax records, etc.)*	
9. How much work time did you lose during the past three years and what was the cause? *(Please use "Additional Information" on page 4 of this form if necessary.)* ❒ Sickness or accident ________ weeks ❒ Holidays ________ weeks ❒ Lack of work ________ weeks	
10. Please give name and address of any family physician or specialist that has diagnosed or treated your asbestos-related or other respiratory condition	
11. When, where, and by whom was each X-ray examination of your chest made during the past three years? *(Please give address and use page 4 of this form if necessary.)*	
Have you had a CT scan of your chest? ❒ Yes ❒ No	If yes, when?
12. Smoking history *(Please see questions 12 and 13 on page 2 of this form.)*	

Please Read Carefully

"I declare all the information I have given on this report is true and correct and I elect to claim compensation for the above-mentioned injuries or disease. I authorize the Workers' Compensation Board (the 'Board') and Review Board to obtain or view, from any source whatsoever, including records of physicians, qualified practitioners, medical insurers, or hospitals, a copy of records pertaining to examination, treatment, history, and employment of the undersigned. Further, I acknowledge that the Board may disclose information from my claim to my employer for purposes of appeal, or may disclose such information to others in accordance with the law, including the *Freedom of Information and Protection of Privacy Act*. I authorize the Board to disclose information from my claim to the designated advocate of my union or similar association. I understand it is a serious offence to knowingly make a false claim or to work and earn income while receiving workers' compensation without advising the Board."

Worker's signature	Date *Month Day Year*	Personal health number from your BC CareCard

☛ **ADDITIONAL INFORMATION CAN BE RECORDED ON PAGE 4 OF THIS REPORT.**
Please see page 4 of this report for telephone and fax numbers.

Worker's last name	First name	Middle initial	Social insurance number	Claim number

Worker's personal health number from BC CareCard									

12. Smoking history: Have you ever smoked? ❒ Yes ❒ No	
If yes, at what age did you start?	If yes, when did you quit?
Are you still smoking?	How many packs of cigarettes did you or do you smoke per day on average? *(packs)*
Did you/do you smoke ❒ Pipe ❒ Cigar	
13. When you worked with/near asbestos, did you wear any respiratory protection? ❒ Yes ❒ No	If yes, what?

Worker's employment history

Please list all employers and any military service duties from the time you left school. Show all job categories held and length of time in each. Start with your first employment and proceed to your most recent employment.

Employer's name, location, and province	Years (from/to)	Occupation	Type of machinery or equipment used

Worker's last name	First name	Middle initial	Social insurance number	Claim number

Worker's personal health number from BC CareCard									

Worker's employment history (continued)

Please list all employers and any military service duties from the time you left school. Show all job categories held and length of time in each. Start with your first employment and proceed to your most recent employment.

Employer's name, location, and province	Years (from/to)	Occupation	Type of machinery or equipment used

Worker's last name	First name	Middle initial	Social insurance number	Claim number

Worker's personal health number from BC CareCard									

Additional information

Personal information on this form is collected for the purposes of administering a worker's compensation claim by the Board in accordance with the ***Workers Compensation Act*** and the ***Freedom of Information and Protection of Privacy Act***. For further information, please contact the Board's Freedom of Information Coordinator at 6951 Westminster Highway, Richmond, BC, V7C 1C6, or telephone 604 279-8171.

Visit our web site at **www.WorkSafebc.com**

Mailing address for application and all claims correspondence: Workers' Compensation Board of BC
PO Box 4700 Stn Terminal
Vancouver BC V6B 1J1

Fax number: Local 604 233-9777 or toll free within BC 1 888 922-8807.

Telephone information

Call the **Lower Mainland and Vancouver Island/Terrace** Call Centre at 604 231-8888 or toll free within BC 1 888 967-5377.

Call the **BC Interior and North** Call Centre at 250 717-4301 or toll free within BC 1 888 922-6622.

Occupational Disease Services, call 604 276-3007 or toll free within BC 1 888 967-5377 (extension 3007).

Other assistance

The Workers' Advisers Office is independent and separate from the WCB and provides free advice and assistance to help injured workers with their claims. The Workers' Advisers have offices throughout the province and can be contacted at **www.labour.gov.bc.ca/wab/** or by telephone at:

Richmond	604 713-0360	or toll free	1 800 663-4261
Victoria	250 952-4393	or toll free	1 800 661-4066
Kelowna	250 717-2096	or toll free	1 866 881-1188