



YUKON WORKERS'
COMPENSATION
HEALTH AND
SAFETY BOARD

401 STRICKLAND STREET
WHITEHORSE, YUKON
Y1A 5N8
TEL: (867) 667-5645
FAX: (867) 393-6279
TOLL FREE 1-800-661-0443

Worker Report of Hearing Loss Background Information

Date: _____

Name: _____

Date of Birth: _____

Address: _____

Contact Phone Number: _____

Health Insurance Number: _____

** A hearing test and written report by an audiologist is required.
Please include, or have the audiologist forward the report to us.*

1. Have you had a claim with any other Board or Agency for hearing loss or any other hearing/ear problems?Yes No

If yes, where:

2. Was your change in hearing.....Sudden? or Gradual?

If it was sudden, explain the circumstances:

3. Have you had a blow/injury to your head and /or ears?..... Yes No

If yes, explain the circumstances:

4. Have you had regular exposure to noise in conjunction with carbon monoxide, lead, manganese, styrene, toluene, xylene, arsenic, carbon disulphide, mercury or trichloroethylene on a regular basis in any of your worksites? Yes No

If yes, details:

5. Have you been exposed to gunfire? _____ Yes No

If yes, do you use a right handed or left handed stance? _____ How often and how recently have you been exposed to gunfire:

6. Have you ever seen a doctor for middle ear problems (e.g. ear infections, burst eardrum etc)? _____ Yes No

If yes, where and when:

7. Have you ever had surgery on your ears? _____ Yes No

If yes, which ear and when:

8. Is there a history of hearing loss or ear disease in your family? Yes No

If yes, who and to what degree:

9. Do you wear hearing aids? _____ Yes No

If yes, details: