Yukon Workers' Compensation Health and Safety Board

WORKER'S REPORT OF INJURY – HEARING LOSS

401 Strickland Street, Whitehorse, Yukon, Y1A 5N8, **Phone:** 867-667-5645, **Toll free:** 1-800-661-0443, **Fax:** 867-667-8740, **Web:** www.wcb.yk.ca

WORKER'S INFORMATION

Last name	First name	Date of birth YYYY/MM/DD

Mailing address	Community/city	Terr./Prov.	Postal code

Social insurance number	Email*	Phone

INFORMATION ABOUT YOUR HEARING LOSS

1. Current employment status:

☐ Employed in Yukon ☐ Retired from Yukon employment in _____.

2. I had a hearing test on _____ at _____
YYYY/MM/DD NAME OF THE CLINIC

in _____. (**Note:** This report will be requested from the clinic.)
CITY

3. The reason for your hearing loss is:

☐ Noise-induced (over a long period of time)
☐ Traumatic (a specific event)
☐ From exposure to chemicals known to cause hearing loss

4. Describe in detail what you believe to be the cause of your hearing loss.

_____

_____

_____

_____

5. Have you been exposed to gunfire?

☐ Yes: ☐ Right-handed stance ☐ Left-handed stance ☐ Other: _____
☐ No

6. Have you ever seen a doctor for your ears?

☐ Yes. Explain: _____

_____

☐ No

7. Do you have a claim for hearing loss or ear injury with any other workers' compensation board in Canada?

☐ Yes: _____
NAME OF THE WORKERS' COMPENSATION BOARD
☐ No

8. Employment History Report from Service Canada is attached ☐ Yes ☐ No

* By providing your email address, you permit YWCHSB to correspond with you by email. To withdraw your email from our system, contact 867-667-5645.

I declare that the information provided is true and correct. I consent to the release from any source to the Yukon Workers' Compensation Health and Safety Board (YWCHSB) of any medical or employment information relevant to my claim. I consent to YWCHSB disclosing to healthcare providers, hospitals, physicians, my employers, other workers' compensation boards, and any other relevant third parties, all relevant information necessary to administer my claim in accordance with the law.

I acknowledge that YWCHSB may collect information it considers relevant to my claim to determine benefit entitlement and that my social insurance number may be used for reporting to Canada Revenue Agency and collecting information from Canada Revenue Agency for the purpose of determining benefit entitlement in accordance with the law.

Signature _____ Date YYYY/MM/DD _____

This information is being collected for the purposes of administering and enforcing the *Workers' Compensation Act* and is collected under the authority of that Act and the *Access to Information and Protection of Privacy Act*. If you have any questions about the collection of this information, please contact the privacy officer at YWCHSB at the above listed address or at 867-667-5645 or 1-800-661-0443.

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