WCB Workers Compensation Board of Manitoba

Phone 204-954-4321
(Toll free 1-855-954-4321)
333 Broadway, Winnipeg R3C 4W3
wcb.mb.ca

Worker Hearing Loss Report

Claim Number	WHL

Worker Information (Please type all dates as DD/MM/YYYY)

Last Name		First Name	
Address			Phone Number
City	Province	Postal Code	Date of Birth (DD/MM/YYYY)
Social Insurance Number	Gender	PHIN	Job Title

Employer Information

Business Name			Address
City	Province	Postal Code	Phone Number

Injury Details

1. When were you first aware of a hearing problem?
   Did you report this to your employer? ☐ Yes ☐ No If yes, when?
   Name and title of person reported to:

2. Was the hearing loss ☐ Sudden or ☐ Gradual?
   If sudden, please explain:

3. Have you ever had any of the following illnesses/conditions? In both sections check the appropriate box beside each of the following:

Illness/Condition		Physician attended and date(s), if applicable
Dizziness	☐ Yes ☐ No	
Meningitis	☐ Yes ☐ No	
Nasal Allergies	☐ Yes ☐ No	
Mumps	☐ Yes ☐ No	
Measles	☐ Yes ☐ No	
Scarlet Fever	☐ Yes ☐ No	
Head Injury	☐ Yes ☐ No	

	Which ear was effected?	Physician attended and date(s), if applicable
Ear Injury	☐ Right ☐ Left ☐ Both ☐ Neither	
Ear Surgery	☐ Right ☐ Left ☐ Both ☐ Neither	
Discharge from Ears	☐ Right ☐ Left ☐ Both ☐ Neither	
Ringing Ears	☐ Right ☐ Left ☐ Both ☐ Neither	

4. Is there a history of deafness/hearing impairment in your family? ☐ Yes ☐ No
   If yes, please explain:

5. Have you taken or do you take any medication on a regular basis? ☐ Yes ☐ No
   If yes, please indicate medication(s):

6. Is the noise at work ☐ Continuous ☐ Occasional

7. At work, which ear protection do you use?
   ☐ Plugs ☐ Muffs ☐ Both ☐ Make and Model
   When did ear protection become available?
   How long have you been wearing hearing protection?

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8. Have you ever had your hearing checked? ☐ Yes ☐ No
Name of the person performing tests:
Address:
Date(s):

9. Have you, or do you intend to file a claim for hearing loss with another Workers Compensation Board? ☐ Yes ☐ No
If yes, which board?
Was the claim accepted? ☐ Yes ☐ No

10. Have you ever, or do you **currently,** take part in the following:

	How often?
Car Racing/Flying ☐ Yes ☐ No	
Snowmobiling/Motorcycling ☐ Yes ☐ No	
Power Boating ☐ Yes ☐ No	
Farm Machinery Operation ☐ Yes ☐ No	
Home Power Tool Operation (e.g.: Saws Drills, Grinders) ☐ Yes ☐ No	
Loud Music Radio/Stereo Headphones Amplified/Musical Instruments ☐ Yes ☐ No	
Hunting/Shooting ☐ Right Handed ☐ Left Handed ☐ Yes ☐ No	

11. Have you ever been in the Armed Forces? ☐ Yes ☐ No If yes, please provide service number _____
In what trade? _____ Were you ever exposed to gunfire? ☐ Yes ☐ No
Date of service: From _____ (year) to _____ (year)
Do you receive a pension with regards to your hearing difficulties? ☐ Yes ☐ No

12. Are you attributing your hearing loss to employment with one specific employer, certain employers, or to your work experience ingeneral?
Please explain:

13. Have you ever been exposed to a loud blast or explosion? ☐ Yes ☐ No
If yes, please explain:

TO BE COMPLETED BY ALL WORKERS

I certify that the information given on this and preceding pages is true, correct and complete in every respect. I agree to notify the Workers Compensation Board of Manitoba immediately of any change in circumstances affecting this claim, including any return to work or any income earned from employment.

I understand that the *Workers Compensation Act* provides that it is an offence, punishable by fine and/or imprisonment for a person to:
a) knowingly make a false statement to the WCB affecting the person's entitlement to compensation; and
b) to deliberately fail to inform the WCB of a material change in circumstance affecting the person's entitlement to compensation within ten days of the commencement of the change.

Release for Medical Information

I authorize the Workers Compensation Board of Manitoba to obtain any and all medical information including audiograms and other audiological assessment pertinent to this claim and to conduct such other investigations as may be necessary for the adjudication of this claim.

Release for Income Information from Canada Revenue Agency

This is your authorization to provide the Workers Compensation Board of Manitoba with copies of my complete income tax return(s) and other taxpayer information including all supporting information slips, schedules and financial statements. The information will be used:
(1) to assist in establishing my net average earnings, and
(2) to determine and verify eligibility for benefits under the *Workers Compensation Act*.

This authorization is valid for the two taxation years prior to the year it was signed, the year it was signed, and each following taxation year where benefits are provided.

Workers Signature	Date (mm-dd-yyyy)

Workers Compensation Board of Manitoba

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Work History Summary-Hearing Loss

Claim Number	WHHL

Worker Name

Please outline full details of all your employment, starting with your first job to your most current position. Complete information regarding the Employer's present address and the location where the work was performed, if different then the Employer's present address is required. Please be sure to include any work performed outside of the province and Canada.

Employer Name	
Employer Address	
Brief Description of Occupation & Proximity to Noise	
Type of Machinery or Equipment Used:	
Exposure to Loud Noise hours/day	Was Hearing Protection Worn? ☐ Yes ☐ No
How was your hearing at that time	
Period of Employment- From: to	

Employer Name	
Employer Address	
Brief Description of Occupation & Proximity to Noise	
Type of Machinery or Equipment Used:	
Exposure to Loud Noise hours/day	Was Hearing Protection Worn? ☐ Yes ☐ No
How was your hearing at that time	
Period of Employment- From: to	

Employer Name	
Employer Address	
Brief Description of Occupation & Proximity to Noise	
Type of Machinery or Equipment Used:	
Exposure to Loud Noise hours/day	Was Hearing Protection Worn? ☐ Yes ☐ No
How was your hearing at that time	
Period of Employment- From: to	

Claim Number	E

Employer Name

Employer Address

Brief Description of Occupation & Proximity to Noise

Type of Machinery or Equipment Used:

Exposure to Loud Noise hours/day | Was Hearing Protection Worn? ☐ Yes ☐ No

How was your hearing at that time

Period of Employment-
From: to

Employer Name

Employer Address

Brief Description of Occupation & Proximity to Noise

Type of Machinery or Equipment Used:

Exposure to Loud Noise hours/day | Was Hearing Protection Worn? ☐ Yes ☐ No

How was your hearing at that time

Period of Employment-
From: to

Employer Name

Employer Address

Brief Description of Occupation & Proximity to Noise

Type of Machinery or Equipment Used:

Exposure to Loud Noise hours/day | Was Hearing Protection Worn? ☐ Yes ☐ No

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Employer Name

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Brief Description of Occupation & Proximity to Noise

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Exposure to Loud Noise hours/day | Was Hearing Protection Worn? ☐ Yes ☐ No

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Claim Number	E

Employer Name	
Employer Address	
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How was your hearing at that time	
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Fax this form - Winnipeg: 204-954-4999 | toll free: 1-877-872-3804