WORK SAFE BC

Hearing Loss and Employment Questionnaire

RESET

Please answer all questions and complete this questionnaire in **INK**, and sign on the last page.

Claims Call Centre
Phone 604.231.8888
Toll-free 1.888.967.5377
M–F, 8 a.m. to 6 p.m.

Fax
604.233.9777
Toll-free **1.888.922.8807**

Mail
WorkSafeBC
PO Box 4700 Stn Terminal
Vancouver BC V6B 1J1

Worker information

Customer care number		WorkSafeBC claim number	
Worker last name	First name		Middle initial
Worker's occupation	Preferred first name		Gender ☐ M ☐ F
Address line 1	City	Province/state	Postal code/zip
Address line 2	Country (if not Canada)	Phone number (include area code)	
Business phone (include area code)	Business extension	Email address	
Date of birth (yyyy-mm-dd)	Personal health number (BC CareCard)	Social insurance number	

Employer information

Employer organization name	Phone number (include area code)		
Mailing address 1	City	Province/state	Postal code/zip
Mailing address 2	Country (if not Canada)	Operating location code	
Type of business	Employer's phone number (include area code)		

History

What problems do you notice with your hearing?		
Approximately when were you first aware of problems with your hearing? (yyyy-mm-dd)		
Have you consulted a physician or audiologist regarding your hearing loss? ☐ Yes ☐ No	If yes, indicate name and date of appointment(s)	
Is your hearing better in one ear than the other? Please explain. ☐ Right ear ☐ Left ear	What happened? Was this problem with your hearing: ☐ sudden or ☐ gradual? Please explain.	
Do you have ringing or other noises in your ears? ☐ Yes ☐ No	If yes, which ear? ☐ Right ear ☐ Left ear	If yes, when did you first notice it? (yyyy-mm-dd)

List all medications (prescribed or over-the-counter, including herbal remedies) currently taken

Name	Why are you taking it?

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Do your parents, children, brothers, or sisters have hearing loss? ☐ Yes ☐ No	If yes, specify who	From what age?
Has any member of your family had ear surgery? ☐ Yes ☐ No	If yes, specify who	At what age?

Have you ever had any of the following?				**When?**
Hearing aid	☐ Right ear	☐ Left ear	☐ No	
Ear infection	☐ Right ear	☐ Left ear	☐ No	
Ear pain	☐ Right ear	☐ Left ear	☐ No	
Ear surgery	☐ Right ear	☐ Left ear	☐ No	
Feeling of fullness in your ears	☐ Right ear	☐ Left ear	☐ No	
				When?
Sudden hearing loss		☐ Yes	☐ No	
Serious head injury		☐ Yes	☐ No	
Thyroid problems		☐ Yes	☐ No	
Whiplash		☐ Yes	☐ No	
High blood pressure		☐ Yes	☐ No	
Sudden intense noise (e.g., explosion)		☐ Yes	☐ No	
Diabetes		☐ Yes	☐ No	
Heart disease/attack		☐ Yes	☐ No	
Stroke		☐ Yes	☐ No	
Kidney problems or disease		☐ Yes	☐ No	
Dizziness/balance problems		☐ Yes	☐ No	
Antibiotics by intravenous (IV)		☐ Yes	☐ No	
Serious illness (e.g., cancer, tuberculosis, malaria, meningitis) If yes, what was it and when did you have it?		☐ Yes	☐ No	

Comments

Firearm noise history

Have you **ever** been exposed to any firearms **outside of your work**?				☐ Yes	☐ No
If yes, was it for:	Hunting			☐ Yes	☐ No
	Firing range			☐ Yes	☐ No
	Target/trap/skeet shooting			☐ Yes	☐ No
Check all types of firearms used:					
☐ Rifle	Number of years		Shoulder shot from	☐ Right	☐ Left
☐ Shotgun	Number of years		Shoulder shot from	☐ Right	☐ Left
☐ Handgun	Number of years				

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Recreational noise history

Have you ever used any of the following **outside of your work**?	**Number of years**
☐ Power tools	
☐ Outboard boat engine	
☐ Chain saw	
☐ Small/prop airplane	
☐ Motorcycle	
☐ Car racing	
☐ Amplified music	
☐ Heavy equipment	

Employment record

1. Age you left school	2. Date you retired, if applicable (yyyy-mm-dd)	3. Date you last worked in noise (yyyy-mm-dd)

4. Were you in the military service? ☐ Yes ☐ No	If yes, during what period? (yyyy-mm-dd) From To
What was your job in the service?	
Were you exposed to loud noise or gunfire beyond basic training? ☐ Yes ☐ No	
5. Are you or have you been **dispatched** through a union? ☐ Yes ☐ No	
Name of union	Length of time you worked through the union (yyyy-mm-dd) From To
Your occupation	
List any jobs you were dispatched to **outside** of BC (include locations and time periods for each)	

Self-employment

6. Do you deduct business or equipment expenses from your employment income? ☐ Yes ☐ No	If yes, what is your type of employment? ☐ Hired on a contract basis ☐ Partner or principal ☐ Fisher
7. Company name(s) and location(s)	

8. Do you have an account with WorkSafeBC: Personal Optional Protection (POP)? ☐ Yes ☐ No	If yes, what are your account number(s)?	Date(s) (yyyy-mm-dd)

The Workers' Advisers Office is independent and separate from WorkSafeBC and provides free advice and assistance to help injured workers with their claims. They have offices throughout the province and can be contacted at **labour.gov.bc.ca/wab/** or by telephone: Richmond 604.713.0360, toll-free 1.800.663.4261; Victoria 250.952.4393, toll-free 1.800.661.4066; Kelowna 250.717.2096, toll-free 1.866.881.1188.

WorkSafeBC collects information on this form for the purposes of administering and enforcing the *Workers Compensation Act*. That Act, along with the *Freedom of Information and Protection of Privacy Act*, constitutes the authority to collect such information. To learn more about the collection of personal information, contact WorkSafeBC's freedom of information coordinator at PO Box 2310 Stn Terminal, Vancouver BC, V6B 3W5, or call 604.279.8171.

Please complete the employment history record sheet on page 4.

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9. List all the places you have worked starting from the time you left school until your current or most recent employer. If you don't have the information, Service Canada may be able to help by providing you a copy of your Record of Employment.

Employer's name	Location	Employment period (yyyy-mm)		Type of work (list all jobs for each employer and duration of each job)	Noise sources and exposure to noise (hours per day)	Hearing protection	
		From	To			Yes	No
						☐	☐
						☐	☐
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10. List all time periods you were not working (do not include vacation)

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 understand it is a serious offence to knowingly make a false claim or to work and earn income while receiving workers' compensation benefits without advising WorkSafeBC (the Workers' Compensation Board). I authorize WorkSafeBC and the Workers' Compensation Appeal Tribunal to view or obtain a copy of records pertaining to my examination, treatment, history, and employment from any source whatsoever, including records of physicians, qualified practitioners, medical insurers, hospitals, and any employer. I understand the information is collected, used, and disclosed under the authority of the *Workers Compensation Act* and the *Freedom of Information and Protection of Privacy Act*. I acknowledge that WorkSafeBC may obtain and disclose information from my claim to my employer for the purpose of appeal, or may disclose such information to others in accordance with the law, including the *Workers Compensation Act* and the *Freedom of Information and Protection of Privacy Act*.

11. Signature	12. Date (yyyy-mm-dd)

Thank you for taking the time to complete this questionnaire and please attach extra forms if required.