WORK SAFE.
FOR LIFE.
WORKERS' COMPENSATION BOARD OF NOVA SCOTIA

5668 South Street,
P.O. Box 1150,
Halifax, NS B3J 2Y2

Toll Free: 1-800-870-3331
Local: 1-902-491-8999
Fax: 1-902-491-8001

Occupational Noise-Induced Hearing Loss Application

If, while working in Nova Scotia, you have been exposed to prolonged occupational noise exposure exceeding the *Nova Scotia Occupational Health & Safety Standards* (above 85dBA/8hrs per day), you are eligible to submit an application to the Workers' Compensation Board of Nova Scotia for review of whether you meet the criteria to establish an **occupational noise induced hearing loss** (ONIHL) claim.

Please complete and submit the following enclosed documents to begin the application process:

- ***Personal Information Questionnaire*** – Please note that the declaration and consent page must be signed.
- ***Current Employer Questionnaire*** – If you are presently working, *this* form must be completed by your current employer if you are exposed to hazardous noise in excess of 85dBA at your current job.
- ***Worker's Employment History***
  - Include all years of employment *from the date you left school* until the present date, or date of retirement; whichever comes first.
  - Attach copies of all employment screenings or audiograms regardless of whether they were performed in Nova Scotia or another province/territory.
  - If you are/were a member of a labour organization, please attach a letter from the union confirming the date you joined the union, the companies you were dispatched to, and the dates you worked for these companies.

IMPORTANT: If you are unable to complete the Worker's Employment Record form *in full*, please fill out the attached Service Canada Form letter and MAIL it to the following address to request a copy of your employment history. Service Canada will return this information to you and then you can forward it to the WCB.

Service Canada
Contributor Client Services
Canada Pension Plan
PO Box 818 Station Main
Winnipeg, MB R3C 2N4

Any information that you receive after submitting this application form to the WCB of Nova Scotia can be sent directly to their offices.

When your completed application package and all relevant documents as outlined above are received, your application will be reviewed to determine if your hearing loss has been caused by your Occupational Noise Exposure while working in Nova Scotia. Upon receipt of your application we will send you a letter to let you know the next steps in the process.

IMPORTANT: The WCB needs all of this information in order to process your claim.

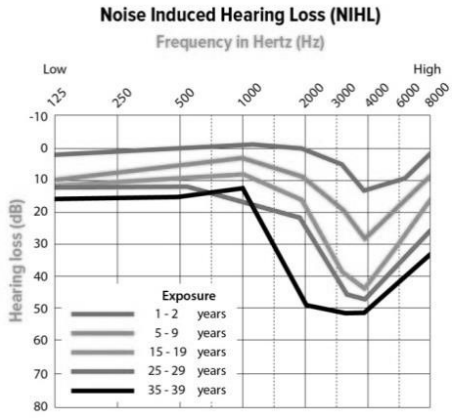
If you have any questions, please call the Integrated Service Centre at **1-800- 870-3331**.

Occupational noise-induced hearing loss is a hearing loss caused by excessive noise posure in the workplace. The occupational exposure limit in Nova Scotia for noise is 85 decibels averaged over an eight-hour workday. Occupational noise-induced hearing loss typically occurs equally in both ears because most noise exposure impacts both ears at the same time.

The WCB of Nova Scotia has several criteria to accept an occupational noise-induced hearing loss claim – you must:

a) Have worked for a WCB-covered employer in Nova Scotia;
b) Have been exposed to hazardous levels of noise while working;
c) Have an audiogram that shows a pattern of hearing loss that is consistent with occupational noise exposure; and
d) Your hearing loss must be at a minimum level of loss to qualify for a permanent impairment benefit.

NOISE-INDUCED HEARING LOSS

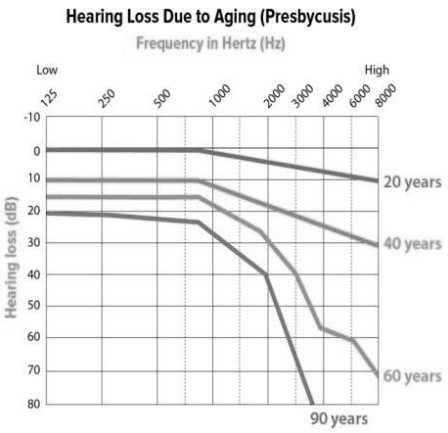


This type of hearing loss typically occurs gradually over time due to prolonged exposure to excessive noise levels greater than 85 decibels. It may also occur from short periods of very intense sound, such as explosive blasts or gun fire—referred to as acoustic trauma.

Noise-induced hearing loss is characterized by a dip in the audiogram. This dip—referred to as a 'notch'—will show up in the audiogram when there is hearing loss between 3000 to 5000 Hertz. The hearing then improves with higher frequencies (above 5000 Hz).

As the noise exposure continues, the dip in the audiogram will deepen and widen (see the black line in the chart above). This type of hearing loss will increase rapidly during the first 10-15 years of exposure.

HEARING LOSS DUE TO AGING



Sometimes hearing loss may be presumed to be noise induced when in fact it is due to the aging process. Understanding the difference is important.

Hearing loss due to aging occurs in both ears and is gradual as we grow older.

In this chart you can see that the hearing loss steady declines with age. This is different from the chart on the left, which shows a dip and then improvement in hearing based on the hearing frequency (Hz).

This type of hearing loss usually begins with high frequency noises and then moves to the mid to lower frequencies.

Characteristics not typical of noise-induced hearing loss

The following characteristics are **not** of a typical noise-induced hearing loss and may be related to other causes:

- The hearing loss is in the low to mid frequencies.
- The hearing loss is fairly constant or "flat" across frequencies.
- There is a profound hearing loss (greater than 80 decibels).
- The hearing loss is worse in one ear than the other.
- There is rapid hearing loss late in the career.
- Hearing continues to get worse after you are no longer working in a noisy environment.

Your audiologist can help you

If you are uncertain whether you have an occupational hearing loss, your audiologist is a good source of information. He/she can review your audiogram pattern and work history with you and advise you on hearing loss treatment. If your hearing loss is not typical of noise-induced hearing loss or aging, your audiologist may recommend that you follow up with an ear, nose and throat specialist.

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Personal Information

Please Print Clearly

WCB CLAIM NUMBER:

CLAIMANT'S INFORMATION			
Last Name:	First Name:		Initial(s):
Claimant's Address (APT/UNIT #, CIVIC #, STREET):	City/Town	Prov.:	Postal Code:
Phone Number:	Date of Birth (YYYY/MM/DD):	Sex:	
Health Card Number:	If retired, date of retirement (YYYY/MM/DD):		
If no longer a resident of Nova Scotia, date you left province (YYYY/MM/DD):			
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?	when?		
During any of your employment years, were you self-employed? ☐ Yes ☐ No			
If yes, please provide the following information:			
Company Name:	Occupation:	WCB Account Number:	
To review an occupational hearing loss application, we require a diagnostic hearing assessment done by a Certified Audiologist.			
When did you first know your hearing loss may have been caused by noise exposure in your workplace.			
Date (YYYY/MM/DD):	Who told you? (FIRST NAME, LAST NAME, RELATIONSHIP TO YOU)		

CLAIMANT'S NAME:	WCB CLAIM #:

HEARING HISTORY

When did you become aware of your hearing loss? (YYYY/MM/DD)

Is your hearing better in one ear than the other? ☐ Yes ☐ No Which ear is better? ☐ Left ☐ Right

Was your change in hearing ☐ Sudden? ☐ Gradual?

If sudden, which ear was affected? ☐ Left ☐ Right ☐ Both

If sudden, please explain:

Have you ever had your hearing tested by any of the following? If yes, please provide the following and attach copies of the hearing test(s). **We require a diagnostic hearing assessment done by a Certified Audiologist.**

	Yes	No	Date (YYYY/MM/DD)	Name of Facility	Phone Number/Address
Audiologist	☐	☐			
Hearing Aid Practitioner	☐	☐			
Physician	☐	☐			
ENT Specialist	☐	☐			
Employer	☐	☐			
Other (SPECIFY) _____	☐	☐			

Do you or have you ever worn a hearing aid? ☐ Left ☐ Right ☐ Both

Please provide the name of supplier and dates of purchase:

Date (YYYY/MM/DD)	Type of Hearing Aid	Name of Facility	Phone Number/Address

CLAIMANT'S NAME:	WCB CLAIM #:

HEARING HISTORY, CONTINUED

Do you experience ringing or other noises in your ears? ☐ Yes ☐ No

If yes, which ear? ☐ Left ☐ Right ☐ Both

If yes, is the noise ☐ Constant? ☐ Intermittent? If yes, when did it begin? (YYYY/MM/DD)

If you have you experienced any of the following, please provide date, specific names, and addresses of facility where treatment was sought:

Condition	L	R	B	Date (YYYY/MM/DD)	Name of Facility	Phone Number/Address
DIzziness/ Balance Problems	☐	☐	☐			
Ear Infection	☐	☐	☐			
Ear Pain	☐	☐	☐			
Ear Pressure/ Fullness	☐	☐	☐			
Ear Surgery	☐	☐	☐			
Other (SPECIFY) _____	☐	☐	☐			

If you are currently experiencing any of the above problems and have not sought medical treatment, we would advise that you do so. Please notify us of the physician's name and date of appointment.

Is there a history of deafness or ear disease in your immediate or extended family? ☐ Yes ☐ No

If yes , please supply the following information:

Relationship of Family Member	Cause of Hearing Loss	Approximate Age of Diagnosis

CLAIMANT'S NAME:	WCB CLAIM #:

MEDICAL HISTORY

List diagnosis of conditions that required treatments, i.e.; cancer diabetes, heart issues, kidney problems, etc.

Condition	Date of Diagnosis	Physician/Facility	Phone Number/Address of Physician/Facility

If you are currently experiencing any of the above problems and have not sought medical treatment, we would advise that you do so. Please notify us of the physician's name and date of appointment.

Are you currently on any regular medications for the conditions listed above?

Medication & Condition	Date Prescribed	Physician/Facility	Phone Number/Address of Physician/Facility

CLAIMANT'S NAME:	WCB CLAIM #:

RECREATIONAL EXPOSURE

Please list any recreational exposure and time, i.e. music, car racing, chainsaw, etc.

FIREARMS EXPOSURE

Please list if you have had any firearms exposure and dates:

MILITARY EXPOSURE

Have you served in the Military? ☐ Yes ☐ No Date (YYYY/MM/DD): From To

ADDITIONAL NOTES

Is there any additional information that you would like to provide regarding your hearing loss

Declaration and Consent

I declare that the information provided by me on this questionnaire to be true and correct.

I understand that:

- My social insurance number may be disclosed to past/present employers in order to confirm my employment history
- The WCB of Nova Scotia may collect information that it considers relevant to determine benefit entitlement, including information pre-dating my accident, from any source including physicians, other health care providers, employer(s) and vocational rehabilitation service providers.
- This information is collected to determine my entitlement to compensation under the W*orkers' Compensation Act*.
- The WCB of Nova Scotia may use and disclose the information collected to determine entitlement, to provide services and benefits and, as required or authorized by law. This information may be used and disclosed pursuant to the *Workers' Compensation Act* and the *Freedom of Information and Protection of Privacy Act*.

Signature	Date (YYYY/MM/DD):	Social Insurance Number

Signing the above consent enables the Workers' Compensation Board to process your claim.

The personal information on this form is being collected in compliance with sections 33(a) & (c) of the *Freedom of Information and Protection of Privacy* (FOIP) *Act* and will be used for the purpose of adjudicating your hearing loss claim. The information will be treated in accordance with the privacy protection provisions of Part 2 of the FOIP Act.

I authorize and request WCB Nova Scotia to release or discuss any and all information related to this claim, that was gathered in accordance with claims adjudication under the *Worker's Compensation Act*, to:

Name	Phone:	Relationship to Me

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Current Employer

To be completed by the employer only

WCB CLAIM NUMBER:

WORKER'S INFORMATION

Last Name:	First Name:		Initial(s):
Worker's Address (APT/UNIT #, CIVIC #, STREET):	City/Town	Prov.:	Postal Code:
Date of Birth (YYYY/MM/DD):	Phone Number:	Social Insurance Number:	
Company Name (AS SUPPLIED BY WORKER):	Occupation:	Date of Employment (YYYY/MM/DD): From / To	

EMPLOYMENT HISTORY

Date of Employment (YYYY/MM/DD): From / To	Position:	Province:
Date of Employment (YYYY/MM/DD): From / To	Position:	Province:
Date of Employment (YYYY/MM/DD): From / To	Position:	Province:

We are unable to confirm employment as stated above for one of the following reasons: (Please check appropriate box)

- ☐ We have no personnel files dating back beyond this date (YYYY/MM/DD):
- ☐ The company has changed ownership as of the following date (YYYY/MM/DD):

You may contact the former owner:

Phone number/address:

- ☐ We have searched our records and spoken to long time employees. We have been unable to confirm this claimant's employment with us.
- ☐ Other (PLEASE EXPLAIN):

CLAIMANT'S NAME:	WCB CLAIM #:

SAFETY PRECAUTIONS

Was hearing protection provided? ☐ Yes ☐ No

Did you have a policy which required or enforced the use of hearing protection? ☐ Yes ☐ No

HEARING ASSESSMENTS

Check appropriate box and complete.

☐ Audiograms have been taken and **all copies are attached**.

☐ Audiograms have been taken and copies can be obtained from:

Name: Phone Number:

☐ Hearing assessments have not been completed for our employees.

☐ Any additional comments you wish to provide would be appreciated. e.g. any pre-existing problems, any knowledge of traumatic injury, etc.

NOISE LEVEL READINGS

Check appropriate box and complete.

☐ Noise level readings have been taken and **copies are attached**.

☐ Noise level readings have been taken and copies can be obtained from:

Name: Phone Number:

☐ Sound measurements have not been completed.

☐ List the equipment, tools, machinery, etc. that the worker would have used or would be located near the work area.

CLAIMANT'S NAME:	WCB CLAIM #:

CONFIRMATION AND SIGNATURE	
We wish to thank you for your time in providing this information.	
Name of Company:	Phone Number:
Name of Person Completing Form (PLEASE PRINT):	Position:
Signature:	Date (YYYY/MM/DD):

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Worker's Employment History

WCB CLAIM NUMBER:

WORKER'S INFORMATION

Last Name:	First Name:		Initial(s):
Worker's Address (APT/UNIT #, CIVIC #, STREET):	City/Town	Prov.:	Postal Code:
Phone Number:	If retired, date of retirement (YYYY/MM/DD):	Sex:	
If no longer a resident of Nova Scotia, date you left province (YYYY/MM/DD):			

INSTRUCTIONS

1. List all employers and military service duties from the time you left school. Show all job categories held and length of time in each.
2. In completing this form, start with your first employment and proceed to your most recent employment.
3. **Please complete this form even if submitting a record of employment from CPP**

EMPLOYMENT HISTORY

Employer's Complete Name:	Province:	Date of Employment (YYYY/MM/DD): From:	To:
Job Position & Description of Job Duties:		Source of Noise Exposure:	
Duration of Noise Exposure:		Hearing Protection Used:	
Employer's Complete Name:	Province:	Date of Employment (YYYY/MM/DD): From:	To:
Job Position & Description of Job Duties:		Source of Noise Exposure:	
Duration of Noise Exposure:		Hearing Protection Used:	

CLAIMANT'S NAME:	WCB CLAIM #:

EMPLOYMENT HISTORY

Employer's Complete Name:	Province:	Date of Employment (YYYY/MM/DD): From: To:
Job Position & Description of Job Duties:		Source of Noise Exposure:
Duration of Noise Exposure:		Hearing Protection Used:
Employer's Complete Name:	Province:	Date of Employment (YYYY/MM/DD): From: To:
Job Position & Description of Job Duties:		Source of Noise Exposure:
Duration of Noise Exposure:		Hearing Protection Used:
Employer's Complete Name:	Province:	Date of Employment (YYYY/MM/DD): From: To:
Job Position & Description of Job Duties:		Source of Noise Exposure:
Duration of Noise Exposure:		Hearing Protection Used:
Employer's Complete Name:	Province:	Date of Employment (YYYY/MM/DD): From: To:
Job Position & Description of Job Duties:		Source of Noise Exposure:
Duration of Noise Exposure:		Hearing Protection Used:
Additional Notes:		

CLAIMANT'S NAME:	WCB CLAIM #:

EMPLOYMENT HISTORY

Employer's Complete Name:	Province:	Date of Employment (YYYY/MM/DD): From: To:
Job Position & Description of Job Duties:		Source of Noise Exposure:
Duration of Noise Exposure:		Hearing Protection Used:
Employer's Complete Name:	Province:	Date of Employment (YYYY/MM/DD): From: To:
Job Position & Description of Job Duties:		Source of Noise Exposure:
Duration of Noise Exposure:		Hearing Protection Used:
Employer's Complete Name:	Province:	Date of Employment (YYYY/MM/DD): From: To:
Job Position & Description of Job Duties:		Source of Noise Exposure:
Duration of Noise Exposure:		Hearing Protection Used:
Employer's Complete Name:	Province:	Date of Employment (YYYY/MM/DD): From: To:
Job Position & Description of Job Duties:		Source of Noise Exposure:
Duration of Noise Exposure:		Hearing Protection Used:
Additional Notes:		

Service Canada
Contributor Client Services
Canada Pension Plan
PO Box 818 Station Main
Winnipeg, MB R3C 2N4

After completing the form below, mail to Service Canada

I am pursuing a claim for noise–induced hearing loss with the Workers' Compensation Board (WCB) of Nova Scotia. They require confirmation of my complete employment history.

Please provide the following:

- Name of employers
- City/Province
- Years worked at each employer

Earnings and contributions information is not required.

The following information is provided to assist in the retrieval of my employment records. My mailing address is noted below.

I thank you in advance for your prompt reply to my request.

Name: _____

Date of Birth: _____

Social Insurance Number: _____

Signature: _____

Date: _____

Mailing Address: _____

_____

_____

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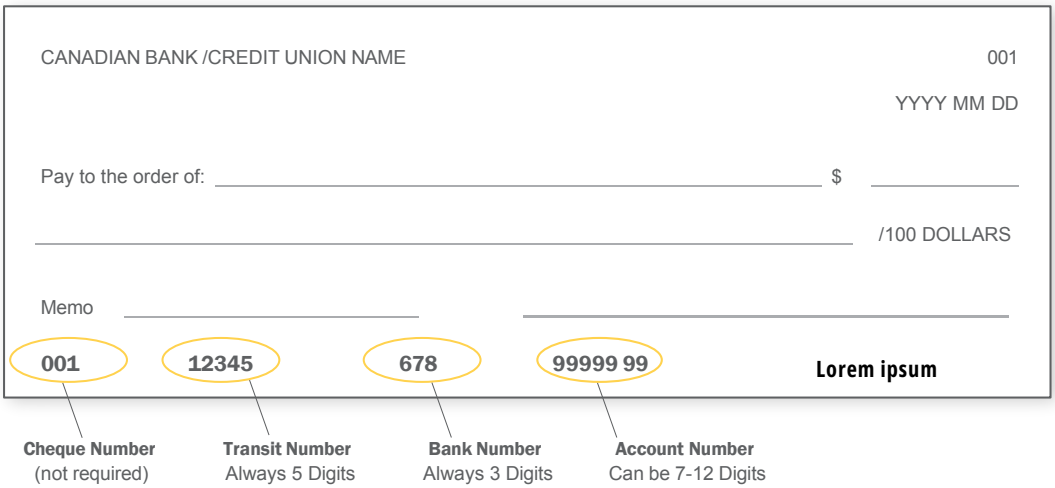
Direct Deposit Enrollment

WCB Nova Scotia offers direct deposit for many types of benefits such as monthly benefits, temporary benefits and payments for travel expenses. To receive benefits that are available through direct deposit, please complete the form and fax it to 1-902-491-8001. It may be mailed to:

WCB Nova Scotia, 5668 South Street, P.O. Box 1150, Halifax, Nova Scotia B3J 2Y2

REQUIRED INFORMATION		
Last Name:	First Name:	Date of Birth (YYYY/MM/DD):
Health Card Number:	WCB Claim Number:	Phone Number:
Current Mailing Address:		
Financial Institution:		
Transit Number:	Bank Number:	Account Number:
Signature of Workers or Recipient of the WCB Benefit*:		Date (YYYY/MM/DD):

* This form must be signed by the person receiving payment in order to be processed.



Note: Please attach a personalized deposit slip or cheque marked "VOID". If this is not possible, your branch can assist you in completing the account information.