WorkplaceNL

MAIL FORM TO:
P.O. Box 9000 St. John's NL A1A 3B8

CALL US AT:
709.778.1000
1.800.563.9000

EMAIL FORM TO:
info@workplacenl.ca

VISIT US AT:
workplacenl.ca

FAX FORM TO:
709.778.1302
1.800.276.5257

6-S

Worker's Report of Occupational Disease

Instructions

- Complete and accurate information is important to avoid delays in processing your claim.
- Ensure you provide as much detail as possible about your work exposures. If you have additional information, attach additional pages and include your name and SIN number on each page.
- Please print or type, and remember to sign Section F.

SECTION A – GENERAL INFORMATION

Last name	First name	Initial(s)	Date of birth (YYYY/MM/DD)
Mailing address	City/town	Province	Postal code
SIN	MCP	Gender	Male ☐ Female ☐
Cell phone ( )	Home phone ( )	Email	

SECTION B – OCCUPATIONAL DISEASE INFORMATION

2. Name of disease being claimed:

- ☐ Asbestosis
- ☐ COPD
- ☐ Pulmonary fibrosis
- ☐ Silicosis
- ☐ Cancer (Please specify type): _____
- ☐ Other (please specify): _____

3. Please indicate any exposures at work:

- ☐ Asbestos
- ☐ Fire smoke or fire gases
- ☐ Fuel (please specify): _____
- ☐ Silica
- ☐ Rock/mining dust (please specify): _____
- ☐ Chemicals (please specify): _____
- ☐ Other (please specify): _____
- ☐ Unknown

4. Smoking history:

Smoker ☐ Never ☐ Former ☐

Number of years smoked: _____

Number of cigarettes per day: _____

Year quit: _____

5. Are you currently employed? Yes ☐ No ☐

If no, please indicate reason and date you were last employed:

_____

_____

If retired, please give date (YYYY/MM/DD):

_____

6. Have you ever been a member of a union? Yes ☐ No ☐
If yes, please indicate the name, address and telephone number of the local union office.

_____

_____

7. Have you been awarded any benefits from any other agency (i.e., Veterans Affairs, Long Term Disability, Other Workers Compensation Boards) for this condition?

Yes ☐ No ☐

If yes, please indicate the agency:

_____

8. Please list your miners certificate number, if applicable:

_____

SECTION C – MEDICAL INFORMATION

9. Please provide the contact information for your primary health care provider (i.e., family physician, nurser practitioner).

Name	Phone ( )	Fax ( )

Address	City/town	Province	Postal code

10. When was the first time you reported symptoms of your disease to a health care provider? _____
(YYYY/MM/DD)

11. Please list all health care providers and facilities you have visited for this condition. Please start with your most recent, and attach additional paper if necessary.

A) Health care provider's name/facility: _____
Phone: ( ) _____
Fax: ( ) _____

B) Health care provider's name/facility: _____
Phone: ( ) _____
Fax: ( ) _____

C) Health care provider's name/facility: _____
Phone: ( ) _____
Fax: ( ) _____

D) Health care provider's name/facility: _____
Phone: ( ) _____
Fax: ( ) _____

12. Please indicate if you have had any of the following diagnostic tests:

- ☐ Pulmonary function test (PFT)
- ☐ Chest X-ray
- ☐ Computed tomography (CT) scan Magnetic resonance
- ☐ imaging (MRI) scan Chemotherapy/radiation/
- ☐ immunotherapy
- ☐ Positron Emission Tomography (PET Scan)
- ☐ Other (please specify): _____

SECTION D – WORK HISTORY

Important:

- List all the places you have worked both inside and outside of Newfoundland and Labrador, starting with your most recent employer.
- Ensure you provide as much detail as possible about your work exposures. If you have additional information, attach additional pages and include your name and SIN on each page.

Employer name		Phone ( )
Employer address	City/town	Province Postal code
Contact person	Please list all position(s)/occupation(s):	
Start date:	End date:	
Potential exposures:		

Employer name		Phone ( )
Employer address	City/town	Province Postal code
Contact person	Please list all position(s)/occupation(s):	
Start date:	End date:	
Potential exposures:		

Employer name		Phone ( )
Employer address	City/town	Province Postal code
Contact person	Please list all position(s)/occupation(s):	
Start date:	End date:	
Potential exposures:		

SECTION E – INFORMATION ACCESS AUTHORIZATION

14. Do you authorize another individual (e.g., family member, union representative, MHA) to act on your behalf and access your information regarding this claim? ☐ Yes ☐ No

This authorization will remain in effect until you notify WorkplaceNL of a change using Form 13.

Last name	First name	Address	Organization (if applicable)	Phone

SECTION F – SIGNATURE, CONSENT, AND DECLARATION

I believe this is an injury related to my work and I declare that all information I have provided to WorkplaceNL is true and correct. I understand I must immediately inform WorkplaceNL if I return to, or become capable of, performing work of any kind.

I consent to WorkplaceNL collecting and using all information it considers relevant for the purposes of determining my entitlement to benefits and managing my claim under the Workplace Health, Safety and Compensation Act, 2022, (the Act). This includes, but is not limited to, collecting and using information from physicians, hospitals, health care providers and employers pertaining to my examinations, treatment, medical history, injury/incident and employment.

I consent to WorkplaceNL disclosing to my employer or my employer's authorized representative, a summary of my injury costs, which is disclosed to the employer for the purpose of verifying claims' costs. I consent to WorkplaceNL disclosing to external physicians, hospitals and health care providers all relevant information necessary for the purpose of determining entitlement to benefits and managing my claim under the Act.

I understand information may be collected, used and/or disclosed for other purposes and/or disclosed to other parties only as permitted by law, including, but not limited to, the Act, the Access to Information and Protection of Privacy Act and the Personal Health Information Act, and I agree that this consent is valid for the duration of my claim.

Name (please print)	Signature	Date (YYYY/MM/DD)

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April 2025

DIRECT DEPOSIT AUTHORIZATION WORKERS

To ensure benefits are paid in a timely manner, please provide direct deposit information using one of the following methods:

1. Use the MyWorkplaceNL online portal for fast, simple and secure service. Visit MyWorkplaceNL.ca and select "Submit Documents and Requests".
2. Complete sections A and C and attach a void cheque or pre-authorized payment form (available from your financial institution).
3. Complete sections A, B and C in full. If a void cheque is not provided, this form must be stamped by your financial institution.

Section A: Worker information

Worker's last name	Worker's first name	Initial	Claim number (if known)

Mailing address	City / Town

Primary phone	Work phone	Province	Postal code

Section B: Account information (not required if void cheque or pre-authorized payment form attached)

Transit No.

Institution No.

Account No.

Name(s) of account holder(s)

Financial Institution Stamp Here

Section C: Signature

I, as the worker/dependent, am entitled to receive payment(s) from WorkplaceNL and authorize WorkplaceNL to deposit the payment(s) directly into my account until further notice.

X

Signature of worker/dependent

Year Month Day

This information is collected under the authority of the Workplace Health, Safety and Compensation Act, 2022 to process benefits/payments and manage your claim. For more information, please see WorkplaceNL's Policy GP-01: Information Protection, Access and Disclosure available at workplacenl.ca