WorkplaceNL

MAIL FORM TO:
146-148 Forest Road
P.O. Box 9000 St. John's NL A1A 3B8
CALL US AT:
709.778.1000
1.800.563.9000

FAX FORM TO:
709.778.1302
1.800.276.5257

VISIT US AT:
workplacenl.ca

6-S

Worker's Report of Occupational Disease

Worker's last name	Worker's first name		**Give name and address of employer where you were last exposed to hazardous material?**		
Mailing address	Occupation		Company name		
City or town	Province	Postal Code	Company address		
Accident date YY MM DD	Phone		City or town	Province	Postal Code
Cell phone	Email		Social insurance number		

Date of birth YY MM DD	Gender M F	MCP number	Type of business	Date of employment YY MM DD	Date of termination YY MM DD

Have you previously submitted a claim for occupational disease in this Province? Yes ☐ No ☐

Have you submitted a claim for occupational disease in another Province/State? Yes ☐ No ☐

If YES, where?_____ Claim number (If applicable)_____

Provide all information regarding your diagnosis:_____

Provide names and addresses of all treating Physicians, hospitals attended and all tests conducted (i.e. X-rays, CT scan, pulmonary functions, etc).

Give full particulars of your exposure to the hazardous material showing names of employers with dates of employment with each employer. For additional comments see reverse

Employer's name	Contact person, address and phone	Dates from to

Miner's Certificate No._____

This information is collected under the authority of the Workplace Health, Safety and Compensation Act to determine entitlement to benefits and manage your claim.

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 (WHSC 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 WHSC 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 WHSC 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.

If this report of injury is being submitted electronically, I acknowledge and accept that by typing my name below, it is considered my legal signature and I consent to it being used as such.

Name _____ Signature _____ Date |_|_|_|_|_|_|_|_|
(please print) yyyy/mm/dd

Additional remarks: