WorkplaceNL

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

FAX FORM TO:
709.778.1320
1.800.276.5257

VISIT US AT:
workplacenl.ca

6HL

Worker's Report of Hearing Loss

SECTION A - GENERAL INFORMATION

1 Last name | First name | Initial | Date of birth yyyy/mm/dd | Gender ☐ M ☐ F

Mailing address | Apt. | City/town | Province | Postal code

Home phone | Work phone | Social Insurance Number | MCP | Last / current occupation:

Cell phone | Email

2 Are you currently employed? ☐ Yes ☐ No **If yes, please have your current employer complete the Employer's Information Questionnaire.** If no, provide the date you were last employed and proceed to Section B yyyy/mm/dd

SECTION B - MEDICAL INFORMATION (CURRENT HEARING PROBLEM)

3 Has your current hearing problem resulted from noise exposure over time? If no, do not proceed with this form. Instead, complete a Form 6 - Worker's Report of Injury. ☐ Yes ☐ No When did you first seek medical attention for your current hearing problem(s)? yyyy/mm/dd

4 Reason for medical attention: ☐ Difficulty understanding others ☐ Cannot hear ☐ Dizziness ☐ Family history of hearing loss ☐ Earache / pain ☐ Other: _____

5 Have you previously seen an audiologist? ☐ Yes ☐ No | If yes, state name of audiologist | Date of audiology assessment yyyy/mm/dd | **An audiologist's report must be submitted with all applications for occupational hearing loss. If you have not had an audiologist's assessment, please have this assessment completed and the report submitted to WorkplaceNL for review.**

6 Have you seen an Ear, Nose and Throat (ENT) specialist for your ears? ☐ Yes ☐ No | If yes, name of ENT specialist: | Date of ENT visit yyyy/mm/dd

7 Did you have an audiogram / hearing test performed during your current employment or at the time of termination with your most recent employer (where there was exposure to noise)? ☐ Yes ☐ No

SECTION C - MEDICAL INFORMATION (PRIOR EAR PROBLEMS)

8 What type of ear problems have you had in the past? ☐ None ☐ Hole in eardrum ☐ Earache ☐ Ear surgery ☐ Head injury ☐ Other _____ | Provide details of prior ear problems: **names of attending doctor / ear specialist / audiologist**

9 Do you wear hearing aids? ☐ Yes ☐ No | If *yes*, date obtained yyyy/mm/dd | Where did you obtain your hearing aid?

10 Have you submitted a claim for occupational hearing loss in another province / country? ☐ Yes ☐ No | Indicate where the claim was submitted and provide a claim number: Province / Country | Claim #

11 Have you experienced ringing (tinnitus) in your ears? ☐ Yes ☐ No | If yes, which ear(s)? ☐ Right ☐ Left | If yes, is the noise ☐ Constant ☐ Intermittent | If yes, for how long? ☐ Less than two years ☐ More than two years

SECTION D - NON-WORK RELATED NOISE EXPOSURE

12

Source of non-work related noise exposure	Details	Hearing protection
☐ Yes ☐ No Power tools		☐ Yes ☐ No ☐ Partial
☐ Yes ☐ No Firearms		☐ Yes ☐ No ☐ Partial
☐ Yes ☐ No Recreational vehicle		☐ Yes ☐ No ☐ Partial
☐ Yes ☐ No Snowblowers / lawnmowers		☐ Yes ☐ No ☐ Partial
☐ Yes ☐ No Music / band member		☐ Yes ☐ No ☐ Partial
☐ Yes ☐ No Other		☐ Yes ☐ No ☐ Partial

This information is collected under the authority of the Workplace Health, Safety and Compensation Act, 2022 to determine entitlement to benefits and manage your claim.

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Worker's Report of Hearing Loss (Form 6HL)

Worker's name	Social Insurance Number

SECTION E - RETURN-TO-WORK INFORMATION

13 Did you stop working as a result of your hearing loss?

☐ No ☐ Yes →

When did you stop working? yyyy/mm/dd hh:mm ☐ AM ☐ PM

Have you since returned to work? ☐ No ☐ Yes → When? yyyy/mm/dd

Were your work duties and / or hours modified or changed? ☐ Yes ☐ No

Have you been offered or participated in alternate / modified duties? ☐ Yes ☐ No

SECTION F - EMPLOYMENT INFORMATION **Your application cannot be processed without completion of this section.**

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Please type or print clearly

Instructions

Use this form to record any employment exposure including your current employment (if applicable), this also includes self-employment. Please attach additional pages if necessary.

Employer	Province	Employment dates (yyyy/mm)		Job title	Sources of noise exposure	Duration of noise exposure (hours per day)	Type of hearing protection used
		From	To				
		From	To				
		From	To				
		From	To				
		From	To				
		From	To				
		From	To				
		From	To				
		From	To				
		From	To				
		From	To				

SECTION G - INFORMATION ACCESS AUTHORIZATION

15 Do you authorize another individual (e.g., union representative, friend) 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 City/Town	Organization if applicable	Phone

SECTION H - SIGNATURE, CONSENT AND DECLARATION

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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 and the Access to Information and Protection of Privacy 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 (please print) _____ Signature _____ Date yyyy/mm/dd

SECTION I - COOPERATION AND OBLIGATION

All workers and employers must cooperate in early and safe return to work. A re-employment obligation may exist if there are 20 or more workers with your employer and if you have been continuously employed for more than one year. Contact your employer to determine if this re-employment obligation applies to you.

If attaching additional information, put your first name, last name and Social Insurance Number at the top of each sheet.

WorkplaceNL Use Only

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April 2025

Employer's Information Questionnaire

To be completed by the employer only

SECTION A - GENERAL INFORMATION

1

Worker's Last name | Worker's First name | Initial | Date of birth yyyy/mm/dd | Gender ☐ M ☐ F

Mailing address | Apt. | City/town | Province | Postal code

Last / current occupation: | Social Insurance Number | MCP

Employer name | Date of hire yyyy/mm/dd

SECTION B - EMPLOYMENT HISTORY

2 Please provide dates of employment, province employed in, and occupation(s).

From	To	Occupation	Sources of noise exposure	Province

☐ Unable to confirm employment.

Reason: _____

SECTION C - SAFETY PRECAUTIONS

3

Was hearing protection provided?

☐ Yes ☐ No

Did you have a policy which required or enforced the use of hearing protection?

☐ Yes ☐ No

SECTION D - HEARING ASSESMENTS

4

Have you completed any audiograms or hearing tests for this employee?

☐ Yes (If yes, please attach) ☐ No

☐ Any additional comments you wish to provide? _____
(pre-existing problems, knowledge of traumatic injury, etc.)

SECTION E - NOISE LEVEL READINGS

5

Have noise level readings been completed for the employee's work environment?

☐ Yes (If yes, please attach) ☐ No

SECTION F - SIGNATURE

6

Company name | Contact name | Position / title

Signature _____ Date yyyy/mm/dd | Phone number

WorkplaceNL

Health | Safety | Compensation

Submitting a Hearing Loss Claim

If you have been exposed to two or more years of prolonged occupational noise exposure (above 85 dBA/8 hours per day) while working in Newfoundland and Labrador, you are eligible to submit an application for an occupational noise induced hearing loss claim.

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

1. **Worker's Report of Hearing Loss** (form 6HL) - All sections must be completed. The form also includes a section for your employment record (Section F). Please note that you must:
    - Include all years of employment.
    - Attach copies of all employment audiograms regardless of whether they were performed in Newfoundland and Labrador 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.
2. **Employer's Information Questionnaire** - This form must be completed by your current employer if you are exposed to noise exceeding 85 dBA at your current job. If you are not currently employed, this form is not required.

If you have any questions, please call 1.800.563.9000 or email info@workplacenl.ca.

When your completed application package is received, your application will be reviewed to determine if your hearing loss has been caused by your occupational noise exposure while working in Newfoundland and Labrador.

IMPORTANT: All documents must be completed **in full** and **submitted together** or they will be returned to you for completion before your application is reviewed.

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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