WorkplaceNL

MAIL FORM TO:
146-148 Forest Road P.O. Box 9000
St. John's, NL A1A 3B8
FAX FORM TO:
709.778.1302

CALL US AT:
telephone: 709.778.1000
toll-free: 1.800.563.9000
VISIT US AT:
workplacenl.ca

DVL

NON-SPECIFIC INCIDENT REPORT – WORKER'S CHECKLIST

WORKER'S NAME	CLAIM NUMBER

SECTION A – Job Information

1 JOB TITLE | 2 NUMBER OF YEARS IN THIS JOB | 3 NUMBER OF YEARS IN SIMILAR WORK

4 OTHER JOBS HELD IN THE PAST 10 YEARS *(if applicable)*

5 WHAT IS YOUR INJURY? | 6 DESCRIBE YOUR SYMPTOMS

7 HAVE YOU LOST ANY TIME FROM WORK RELATED TO CURRENT SYMPTOMS? ☐ YES ☐ NO

8 HAVE YOU PARTICIPATED IN MODIFIED DUTIES? ☐ YES ☐ NO

9 WHAT DO YOU DO AT WORK THAT CAUSES YOUR SYMPTOMS
1. ______ 3. ______ 5. ______
2. ______ 4. ______ 6. ______

10 WORK SCHEDULE
Number of hours a day ______ Number of days a week ______ Seasonal ☐ YES ☐ NO
Overtime Hours ______ Breaks: When/how long scheduled: ______

11 ANY CHANGE IN WORK PAST 12 MONTHS? ☐ YES ☐ NO If YES, change in *(check all applicable)* ☐ TASKS ______
☐ EQUIPMENT ______ ☐ TOOLS ______ ☐ SCHEDULE ______

12 USE OF VIBRATING TOOLS (drills, chain saw, etc.): ☐ NO ☐ YES IF YES, LIST ______

13 ☐ DO YOU ALTERNATE FROM ONE TASK TO ANOTHER? OR
☐ DO YOU PERFORM ONE TASK FOR LONG PERIODS (i.e. more than 1½ hrs)?

SECTION B – Personal and Background Information

14 DATE OF BIRTH YEAR | MONTH | DAY
15 RIGHT OR LEFT HAND RIGHT ☐ LEFT ☐
16 HEIGHT
17 WEIGHT

18 WEARS GLASSES ☐ YES ☐ NO IF YES, WHY? ______

19 HAVE YOU BEEN TREATED FOR SIMILAR PROBLEMS IN THE PAST? ☐ YES ☐ NO
IF YES, WHAT TREATMENT? ☐ DR. VISIT ☐ PHYSIOTHERAPY ☐ MASSAGE ☐ MEDICATIONS ☐ CHIROPRACTOR ☐ OTHER
BODY PART AFFECTED

20 HAVE YOU SEEN YOUR DOCTOR FOR: (check all applicable)
DIABETES YES ☐ NO ☐ THYROID PROBLEMS YES ☐ NO ☐
ARTHRITIS: YES ☐ NO ☐ Type ______ Area of Body ______

21 RECENT/CURRENT PREGNANCY ☐ YES ☐ NO

22 ANY PREVIOUS ☐ BACK PROBLEMS ☐ NECK PROBLEMS
☐ BROKEN BONES Part of Body ______ When? YEAR MONTH DAY

SECTION C – Additional Information – *(If you require extra space for details, please use reverse)*

23 **NON-WORK RELATED ACTIVITIES:**
AGES OF CHILDREN OR OTHER DEPENDANTS AT HOME ______

24 PARTICIPATION IN SPORTS? ☐ YES ☐ NO
WHAT AND HOW OFTEN? ______
PARTICIPATION IN RECREATIONAL ACTIVITIES/HOBBIES? ☐ YES ☐ NO
WHAT AND HOW OFTEN? ______

25 ANY MOTOR VEHICLE ACCIDENTS? ☐ YES ☐ NO, IF YES, PLEASE DESCRIBE ANY INJURIES ______
______ Date YEAR MONTH DAY

WORKER SIGNATURE ______ DATE YY MM DD

WorkplaceNL USE ONLY

Please use this section if extra space required for details