WorkplaceNL

MAIL FORM TO:
P.O. Box 9000
St. John's, NL A1A 3B8
FAX FORM TO:
f 709.778.1302

CALL US AT:
t 709.778.1000
t 1.800.563.9000
TOLL FREE FAX:
f 1.800.276.5257

DROP OFF IN PERSON:
146-148 Forest Road
P.O. Box 9000
St. John's, NL, A1A 3B8
VISIT: workplacenl.ca

6HL

SECTION A - GENERAL INFORMATION

Worker's Report of Hearing Loss

WORKER

1	Last name	First name	Initial	Date of birth yyyy/mm/dd	Gender ☐ M ☐ F
	Mailing address	City / Town		Province	Postal code
	Home telephone	Work telephone	Social Insurance Number	MCP	Last / current occupation:
2	Are you currently employed? ☐ Yes ☐ No	If *no*, provide the date you were last employed and proceed to Section B yyyy/mm/dd	Are you the owner / operator of this business? ☐ Yes ☐ No	Were you employed as part of a ESDC program? ☐ Yes ☐ No	

EMPLOYER

3	Employer		Telephone
	Mailing address City / Town	Street address *if different* City / Town	
	Province / Postal code	Supervisor's name	Supervisor's telephone

SECTION B - MEDICAL INFORMATION (CURRENT HEARING PROBLEM)

4	Has your current hearing problem resulted from noise exposure over time? ☐ Yes ☐ No *If no, do not proceed with this form. Instead, complete a Form 6 - Worker's Report of Injury.*	When did you first seek medical attention for your current hearing problems? yyyy/mm/dd	
5	Reason for medical attention: ☐ Difficulty understanding others ☐ Cannot hear ☐ Dizziness ☐ Family history of hearing loss ☐ Earache / pain ☐ Other: _____		
6	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.		
7	Have you seen an Ear, Nose and Throat (ENT) specialist? ☐ Yes ☐ No	If *yes*, name of ENT specialist:	Date of ENT visit yyyy/mm/dd
8	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)

9	What type of ear problems have you had in the past? ☐ None ☐ Earache ☐ Head injury ☐ Hole in eardrum ☐ Ear surgery ☐ Other _____	Provide details of prior ear problems: *names of attending doctor / ear specialist / audiologist*
10	Do you wear hearing aids? ☐ Yes ☐ No	If *yes*, date obtained yyyy/mm/dd — Where did you obtain your hearing aid?
11	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 #
12	Have you experienced ringing (tinnitus) in your ears? ☐ Yes ☐ No	If *yes*, how many years have you had tinnitus? ☐ less than two years ☐ more than two years

SECTION D - NON-WORK RELATED NOISE EXPOSURE

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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* to determine entitlement to benefits and manage your claim.

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

Use this form when:

- You have hearing loss that has occurred over time as a result of exposure to occupational noise. If your hearing loss is a result of a specific injury/incident, please complete a Form 6 – Worker's Report of Injury. A claim for hearing loss as a result of chemical exposure can be submitted on this form or a Form 6. In either case, we may need to contact you for further information.
- As a partner, proprietor or independent operator (also referred to as owner/operator on this form), you have experienced occupational hearing loss. Please note that coverage will be extended only when optional personal coverage has been purchased from WorkplaceNL.

Points to remember:

- Complete and accurate information is important so as not to delay processing your claim.
- An Audiologist's report must be submitted with all applications for occupational hearing loss. If you have not been assessed by an audiologist, please arrange to do so.
- Any details that will help explain the extent of noise exposure are important. For example, you may indicate that you have non-work-related noise exposure to music. You would then provide details in Section D regarding the type of music. Indicate that you play a musical instrument, if that is the case, and how often you play. Details could also include exposure to loud music at social events.
- If you have additional comments, attach additional pages and include your name and SIN on each page.
- Be sure to sign on page 2 so we can process your claim.

Section E: Return-to-work Information

- You and your employer may be able to change your duties and / or hours so you can stay at work while you are receiving medical treatment for your injury. This is called early and safe return to work.
- An early and safe return-to-work plan should be developed in co-operation with your employer, based on the functional abilities information from your health care provider(s).

Section F: Additional Employment

- In Section F, it is important to list all employers you have worked with, even if the employment did not involve exposure to noise, and to include details such as job title and specific types of noise exposure (see example below).

*Additional information on access, release and protection of your information by WorkplaceNL can be found in Policy GP-01: "Information Protection and Access," available at **workplacenl.ca** or by calling **1.800.563.9000**.*

Section F Example:

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

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- List all employers with whom you have worked, regardless of whether or not the employment involved exposure to noise.
- Start with your current or most recent employer. If you have more than four employers, please attach an additional sheet with the information requested below.
- For each employer, please record your job title and the type of noise exposure.
- Codes are provided for:
  - ▸ Employment Location Inside / Outside of Province — I = Inside, O = Outside
  - ▸ Time Hearing Protection Worn During Work Hours — A = All day, P = Part of day, N = Not at all
  - ▸ Type of Hearing Protection Worn — M = Earmuffs, E = Earplugs, O = Other, N = None

	Inside / Outside of Province	Employer's Name	Employer's Address	Employment Period From (yyyy/mm)	Employment Period To (yyyy/mm)	Noise Exposure Hours / Day	Time Hearing Protection Worn	Type of Hearing Protection
1.	I	Airport Corporation	123 Sky Street, Vacationville, NL	1982/01	2005/12	12	P	M
	Job title: Baggage Handler		Type of Noise: Planes, engines, conveyor belts.					
2.	I	XY College	43 School Road, Learningtown, NL	1979/08	1982/01	8	P	P
	Job title: Heavy Equipment Instructor		Type of Noise: Engines, machinery, crushers, etc.					
3.								
	Job title:		Type of Noise:					
4.								
	Job title:		Type of Noise:					

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

Worker's name | Social Insurance Number

SECTION E - RETURN-TO-WORK INFORMATION

14 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 - ADDITIONAL EMPLOYMENT INFORMATION *Your claim cannot be processed without completion of this section.*

15

- List all employers with whom you have worked, regardless of whether or not the employment involved exposure to noise.
- Start with your current or most recent employer. If you have more than four employers, please attach an additional sheet with the information requested below.
- For each employer, please record your job title and the type of noise exposure.
- Codes are provided for:
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	Inside / Outside of Province	Employer's Name	Employer's Address	Employment Period From (yyyy/mm)	Employment Period To (yyyy/mm)	Noise Exposure Hours / Day	Time Hearing Protection Worn	Type of Hearing Protection
1.								
	Job title:		Type of Noise:					
2.								
	Job title:		Type of Noise:					
3.								
	Job title:		Type of Noise:					
4.								
	Job title:		Type of Noise:					

16 Indicate the personal income tax credits you are claiming:

- ☐ a. Basic personal amount
- ☐ b. Full equivalent to spouse amount (If not full amount, then d. applies)
- ☐ c. Number of children under age 18 you are claiming _____
- ☐ d. Other (complete a new TD1 and TD1NL available from Canada Revenue Agency at *www.cra.gc.ca*).

If nothing is indicated above, you will be assumed as (a) basic personal amount.

SECTION G - FISHER'S INFORMATION *To be completed by workers on a fishing vessel.*

17 Vessel name | Vessel length (feet) | Type of motor | *Please provide copies of T4's and/or record of earnings for at least the last five years of fishing employment.*

18 Normal working hours each day | Number of days a week | Length of fishing season each year (weeks) | Are you an owner or part owner of the vessel? ☐ Yes ☐ No

SECTION H - INFORMATION ACCESS AUTHORIZATION

19 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*	Telephone

SECTION I - 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 (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* and the *Access to Information and Protection of Privacy Act* and I agree that this consent is valid for the duration of my claim.

Name *please print* _____ Signature _____ Date yyyy/mm/dd

SECTION J - CO-OPERATION AND OBLIGATION

All workers and employers must co-operate 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.

WORKPLACENL USE ONLY

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