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

6-S

Worker's Report of Occupational Disease

WORKER'S - SURNAME	GIVEN NAMES		***Give name and address of employer where you were last exposed to hazardous material?***
ADDRESS	OCCUPATION		COMPANY NAME
CITY OR TOWN	PROV	POSTAL CODE	COMPANY ADDRESS

ACCIDENT DATE	YY	MM	DD	TELEPHONE NO.	CITY OR TOWN	PROV	POSTAL CODE

DATE OF BIRTH	YY	MM	DD	GENDER		SOCIAL INSURANCE NUMBER	MCP NUMBER	TYPE OF BUSINESS	DATE OF EMPLOYMENT			DATE OF TERMINATION		
				M	F				YY	MM	DD	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 # (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 of employment with each employer.
FOR ADDITIONAL COMMENTS SEE REVERSE

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

Miner's Certificate No._____

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.

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

ADDITIONAL REMARKS: