Saskatchewan Workers' Compensation Board
200 - 1881 Scarth Street
Regina SK S4P 4L1
www.wcbsask.com

Phone: 306.787.4370
Toll free: 1.800.667.7590
Fax: 306.787.4311
Toll free fax: 1.888.844.7773

HLQW

Noise Exposure Questionnaire

First name: _____ Last name: _____

Address: _____

Claim number: _____ Phone numbers(s): _____

Date of birth: _____ Social Insurance Number: _____
(MM/DD/YYYY)

Email address: _____

Have you had a prior claim with any other Workers' Compensation Board or agency across Canada for hearing loss or any other hearing/ear problems? Yes ☐ No ☐

If yes, which province/agency? _____ Claim number: _____

What year did you first notice your hearing difficulties? _____

Was your change in hearing: _____ Gradual: _____ Sudden: _____

If sudden, please explain: _____

Employment history

When completing this form, please write clearly. Begin with your most current or recent employer, ending with your first employer. Attach separate sheets if you need more room.

1. Current or most recent employer: _____ Type of business: _____
   City/town/province: _____ Phone number(s): _____
   Employment from: _____ To: _____
   (MM/DD/YYYY) (MM/DD/YYYY)
   Is this work seasonal? Yes ☐ No ☐
   Occupation/job duties: _____
   _____
   Type of machinery or equipment used: _____
   _____
   Exposure to noise: (hours/shift) _____
   Did you complete any hearing tests while at this employer? Yes ☐ No ☐

2. Previous employer: _____ Type of business: _____
   City/town/province: _____ Phone number(s): _____
   Employment from: _____ To: _____
   (MM/DD/YYYY) (MM/DD/YYYY)

When writing to the WCB, please print name and claim or firm number.

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Name: _____ **WCB claim number:** _____

Is this work seasonal? Yes ☐ No ☐

Occupation/job duties: _____

_____

Type of machinery or equipment used: _____

_____

Exposure to noise: (hours/shift) _____

Did you complete any hearing tests while at this employer? Yes ☐ No ☐

3. Previous employer: _____ Type of business: _____

City/town/province: _____ Phone number(s): _____

Employment from: _____ To: _____
(MM/DD/YYYY) (MM/DD/YYYY)

Is this work seasonal? Yes ☐ No ☐

Occupation/job duties: _____

_____

Type of machinery or equipment used: _____

_____

Exposure to noise: (hours/shift) _____

Did you complete any hearing tests while at this employer? Yes ☐ No ☐

4. Previous employer: _____ Type of business: _____

City/town/province: _____ Phone number(s): _____

Employment from: _____ To: _____
(MM/DD/YYYY) (MM/DD/YYYY)

Is this work seasonal? Yes ☐ No ☐

Occupation/job duties: _____

_____

Type of machinery or equipment used: _____

Exposure to noise: (hours/shift) _____

_____

Did you complete any hearing tests while at this employer? Yes ☐ No ☐

5. Previous employer: _____ Type of business: _____

City/town/province: _____ Phone number(s): _____

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Name: _____ **WCB claim number:** _____

Employment from: _____ To: _____
(MM/DD/YYYY) (MM/DD/YYYY)

Is this work seasonal? Yes ☐ No ☐

Occupation/job duties: _____

_____

Type of machinery or equipment used: _____

_____

Exposure to noise: (hours/shift) _____

Did you complete any hearing tests while at this employer? Yes ☐ No ☐

6. Previous employer: _____ Type of business: _____

City/town/province: _____ Phone number(s): _____

Employment from: _____ To: _____
(MM/DD/YYYY) (MM/DD/YYYY)

Is this work seasonal? Yes ☐ No ☐

Occupation/job duties: _____

_____

Type of machinery or equipment used: _____

_____

Exposure to noise: (hours/shift) _____

Did you complete any hearing tests while at this employer? Yes ☐ No ☐

7. Have you ever had any of the following? (Check all that apply.)

	Right ear	Left ear	When (date):
Hearing aid	☐	☐	_____
Ear infection	☐	☐	_____
Ear surgery	☐	☐	_____
Discharge from ears	☐	☐	_____
Ringing in ears	☐	☐	_____

	Yes	No	When (date):
Thyroid problems	☐	☐	_____
Head injury	☐	☐	_____

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Dizziness/balance problems	☐	☐	_____
Nasal allergies	☐	☐	_____
Heart disease/attack	☐	☐	_____
Stroke	☐	☐	_____
Diabetes	☐	☐	_____
Kidney problems	☐	☐	_____
Serious illness *(eg. cancer, meningitis, etc.)*	☐	☐	_____
High blood pressure	☐	☐	_____
Serious infections *(eg. brain/ears or infections requiring IV antibiotics etc.)*	☐	☐	_____

** If yes, please provide medication taken in question 11 below.*

8. a) Did you ever hunt or shoot for sport? Yes ☐ No ☐ _____ number of years

b) Were you ever in the Armed Forces? Yes ☐ No ☐ _____ number of years

If yes, please supply the following information:

Gun used	Calibre	Shots per year	Which years	Recreation and/or Armed Forces

9. Did you wear hearing protection while handling guns? Yes ☐ No ☐

If yes:

a) What type? _____

b) How often? _____

c) What shoulder do you shoot from? _____

10. Is there a history of deafness or hearing difficulties in your family? Yes ☐ No ☐

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Name: _____ **WCB claim number:** _____

If yes, please explain:

_____

_____

11. Have you taken, or do you take, any medications on a regular basis? Yes ☐ No ☐

    If yes, please list medication, the reason you are taking it and how long you have been taking it:

_____

_____

12. List everyone you have seen for your hearing difficulties, dates of appointments and where you have had a **hearing test.** Please attach a copy of the test results, if available.

_____

_____

_____

Declaration

I declare all the information provided is true and correct. I understand that criminal prosecution or penalties may result from any attempt to (1) obtain compensation benefits by fraudulent means and/or (2) prevent collection of compensation benefits.

_____ _____ (MM/DD/YYYY)

Signature Date