WSCC Workers' Safety & Compensation Commission | ᐃᓕᒃᑲᓇᐃᔭᕆᐊᓕᓪᓚᒃᑐᑦ ᐊᑦᑕᓇᖅᑐᓂᒃ ᐊᒻᒪᓗ ᓇᓕᓕᒫᓂᖅ ᖃᐅᔨᓴᖅᑎᑎᓪᓗᒍ

Worker's Report of Vibration Syndrome

COMPLETE AND RETURN TO THE ADDRESS ON THE BACK OF THIS FORM. PRINT CLEARLY.

WSCC Claim Number

Last Name						Present Employer's Name	
First Name(s)						Employer's Mailing Address - (include postal code and phone number)	
Mailing Address (include postal code)							
						Employer Phone Number and/or Fax	
Phone Number - (include area code)							
Social Insurance Number						Length of Employment with this Company	
Date of Birth	Day	Month	Year	Marital Status	No. of Children	Present Occupation	If off work, give date of layoff
What condition are you applying for? ☐ Hand Vibration Syndrome ☐ Arm Vibration Syndrome ☐ Foot Vibration Syndrome							

GIVE FULL PARTICULARS OF YOUR WORK HISTORY. INCLUDE NAMES AND ADDRESSES OF EMPLOYERS, PERIOD OF EMPLOYMENT, TYPES OF MACHINERY USED AND LENGTH OF TIME YOU USED THEM. WE WILL CONTACT EMPLOYERS TO CONFIRM THIS INFORMATION. REMEMBER THAT INCOMPLETE INFORMATION WILL DELAY THE ADMINISTRATION OF YOUR CLAIM.

IN THE NORTHWEST TERRITORIES/NUNAVUT

Employer's Name, Address (include postal code) and Phone Number	Period From	Period To	Type Of Machinery Used	Days Per Week And/Or Hours Per Day
	YEAR	YEAR		
	YEAR	YEAR		
	YEAR	YEAR		

OUTSIDE THE NORTHWEST TERRITORIES/NUNAVUT

Employer's Name, Address (include postal code) and Phone Number	Period From	Period To	Type Of Machinery Used	Days Per Week And/Or Hours Per Day
	YEAR	YEAR		
	YEAR	YEAR		

Attach Any Additional Information You Have

COMPLETE AND SIGN THIS FORM BEFORE FORWARDING TO THE WSCC

COMPLETE BOTH SIDES OF THIS FORM

WORKER'S CONSENT

I hereby claim compensation for work-related vibration syndrome.

Information Sharing – I understand the WSCC will use the above information about me for the sole purpose of conducting an investigation into this claim. I also understand the WSCC will need to gather more information about my exposure, and medical and work history to administer my claim. For that specific purpose only, the WSCC may disclose some personal information to employers, medical personnel and other relevant third parties.

I authorize the WSCC to provide and gather such information from all necessary sources, including hospital and doctors' records, and employer records.

Information Accuracy – I understand incomplete information from me may delay my claim, and untrue information from me is unlawful.

I declare the information above is true and accurate. I understand it may be a criminal offence to make a false claim, or to work and earn income while receiving workers' compensation without telling the WSCC.

DATE	SIGNATURE
DATE	WITNESS

Head Office: Box 8888 • Yellowknife, NT X1A 2R3 • Telephone: (867) 920-3888 • Toll Free: 1-800-661-0792 • Fax: (867) 873-4596 • Toll Free Fax: 1-866-277-3677
or
Box 669 • Iqaluit, NU X0A 0H0 • Telephone: (867) 979-8500 • Toll Free: 1-877-404-4407 • Fax: (867) 979-8531 • Toll Free Fax: 1-866-979-8501
www.wscc.nt.ca • www.wscc.nu.ca

Ce formulaire est disponible en français.
ᑕᒃᓇ ᑎᑎᖅᑐᒐᖅ ᐊᑐᐃᓐᓇᐅᒋᕗᖅ ᐃᓄᒃᑎᑐᑦ.
Taanna tatatirialik atuinnuinnauvuq Inuktitut.

CS013 0211