

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)								
Phone Number - (include area code)						Employer Phone Number and/or Fax		
Social Insurance Number								
Gender □ M □ F □ X						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 ☐ Foo	ot 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	Pe From	riod 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 To		Type Of Machinery Used	Days Per Week And/Or Hours Per Day			
	YEAR	YEAR					
	YEAR	YEAR					

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 investigation into this claim. I also understand the WSCC will need and work history to administer my claim. For that specific purpose employers, medical personnel and other relevant third parties. For rat wscc.nt.ca or wscc.nu.ca.	to gather more information about my exposure, and medical only, the WSCC may disclose some personal information to
I authorize the WSCC to provide and gather such information for records, and employer records.	rom all necessary sources, including hospital and doctors'
Information Accuracy – I understand incomplete information from unlawful.	me may delay my claim, and untrue information from me is
I declare the information above is true and accurate. I understa work and earn income while receiving workers' compensation	
DATE	SIGNATURE
DATE	WITNESS