If, while working in Alberta, you have been exposed to two or more years of prolonged occupational noise exposure exceeding the *Alberta Occupational Health & Safety Standards* (above 85dBA/8hrs per day), you are eligible to submit an application to the Workers' Compensation Board of Alberta for review of whether you meet the criteria to establish an acceptable occupational noise induced hearing loss claim.

Please complete and submit the following enclosed documents to begin the application process:

- ***Hearing Information Questionnaire*** *(form C042)* – Please note that the declaration and consent page must be signed.
- ***Employer's Information Questionnaire*** *(form C139)* - This form must be completed by your current employer if you are exposed to hazardous noise in excess of 85 dBA at your current job.
- ***Worker's Employment Record*** *(form C131)*
  - Include all years of employment *from the date you left school* until the present date, or date of retirement; whichever comes first.
  - Attach copies of all employment audiograms regardless of whether they were performed in Alberta or another province/territory.
  - If you are/were a member of a labour organization, please attach a letter from the union confirming the date you joined the union, the companies you were dispatched to, and the dates you worked for these companies.
  - IMPORTANT: If you are unable to complete the Worker's Employment Record (C131) form *in full*, please fill out the attached Service Canada Form letter and MAIL it to the following address to request a copy of your employment history.

Service Canada
Contributor Client Services
Canada Pension Plan
PO Box 818 Station Main
Winnipeg MB R3C 2N4.

When you receive this information, please include it with your application package.

When your completed application package and all relevant documents as outlined above are received, your application will be reviewed to determine if your hearing loss has been caused by your Occupational Noise Exposure while working in Alberta.

IMPORTANT: All documents must be completed in full and submitted together or they will be returned to you for completion prior to your application undergoing review.

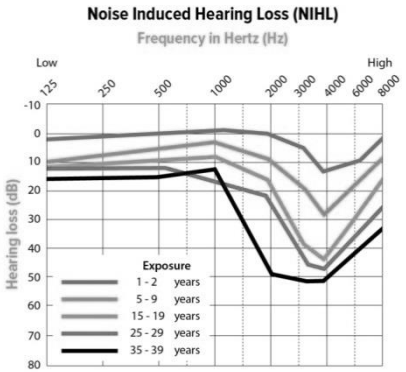
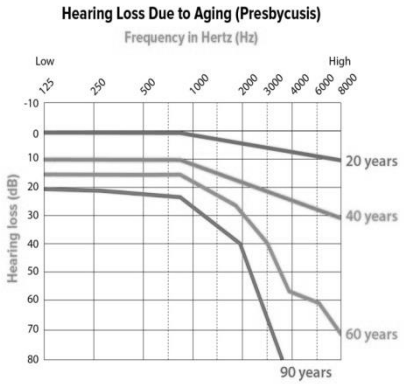
If you have any questions, please call the Customer Contact Centre at 780-498-3999 or toll free in Alberta: 1- 866-922-9221, Canada wide: 1-800-661-9608 and request to have your call transferred to the hearing loss team/hearing loss case assistant.

Occupational noise-induced hearing loss

Occupational noise-induced hearing loss is a hearing loss caused by excessive noise exposure in the workplace. The occupational exposure limit in Alberta for noise is 85 decibels averaged over an eight-hour workday. Occupational noise-induced hearing loss typically occurs equally in both ears because most noise exposure impacts both ears at the same time.

WCB-Alberta has two criteria to accept an occupational noise-induced hearing loss claim—both must be met:

- There must be an audiogram that demonstrates the pattern shown in the noise-induced hearing loss chart below.
- There must be at least two years of noise exposure equal to or greater than 85 decibels averaged over an eight-hour workday (the Alberta occupational exposure limit).

Noise-induced hearing loss	Hearing loss due to aging
This type of hearing loss typically occurs gradually over time due to prolonged exposure to excessive noise levels greater than 85 decibels. It may also occur from short periods of very intense sound, such as explosive blasts or gun fire—referred to as acoustic trauma.  Noise-induced hearing loss is characterized by a dip in the audiogram. This dip—referred to as a 'notch'—will show up in the audiogram when there is hearing loss between 3000 to 5000 Hertz. The hearing then improves with higher frequencies (above 5000 Hz). As the noise exposure continues, the dip in the audiogram will deepen and widen (see the black line in the chart above). This type of hearing loss will increase rapidly during the first 10-15 years of exposure.	Sometimes hearing loss may be presumed to be noise induced when in fact it is due to the aging process. Understanding the difference is important.  Hearing loss due to aging occurs in both ears and is gradual as we grow older. In this chart you can see that the hearing loss steady declines with age. This is different from the chart on the left, which shows a dip and then improvement in hearing based on the hearing frequency (Hz). This type of hearing loss usually begins with high frequency noises and then moves to the mid to lower frequencies.

Characteristics not typical of noise-induced hearing loss

The following characteristics are **not** of a typical noise-induced hearing loss and may be related to other causes:

- The hearing loss is in the low to mid frequencies.
- The hearing loss is fairly constant or “flat” across frequencies.
- There is a profound hearing loss (greater than 80 decibels).
- The hearing loss is worse in one ear than the other.
- There is rapid hearing loss late in the career.
- Hearing continues to get worse after you are no longer working in a noisy environment.

Your audiologist can help you

If you are uncertain whether you have an acceptable claim, your audiologist is a good source of information. He/she can review your audiogram pattern and work history with you and advise you on the application process. If your hearing loss is not typical of noise-induced hearing loss or aging, your audiologist may recommend that you follow up with an ear, nose and throat specialist.

wcb Workers' Compensation Board – Alberta

Box 2415
Edmonton AB T5J 2S5
Tel (780) 498-3999
Fax (780) 427-5863
1-800-661-1993

C042
HEARING INFORMATION

Please print clearly

WCB Claim Number

Personal Health Number

Claimant's *Surname* *First Name* *Initial*

Address *Street* *City/Town* *Province*

Postal Code | Day Time Telephone Number ( ) | Date of Birth *(Year / Month / Day)* | Employee Number

Year and month you left school *(Year / Month)* | If retired, date of retirement *(Year / Month / Day)* | If no longer a resident of Alberta, date you left this province *(Year / Month / Day)*

Have you had a claim with any other Board or Agency for hearing loss or any other hearing/ear problems? ☐ Yes ☐ No

If yes, where? _____ when?

During any of your employment years, were you self-employed? ☐ Yes ☐ No

If yes, please provide the following information: Company name: _____

WCB Account Number: _____ Occupation: _____

HEARING HISTORY

When did you become aware of your hearing loss? (year/month/day) *(Year / Month / Day)*

Is your hearing better in one ear than the other? ☐ Yes ☐ No Which ear is better? ☐ Right ☐ Left

Was your change in hearing ☐ Sudden? ☐ Gradual? If sudden, which ear was affected? ☐ Right ☐ Left ☐ Both

If sudden, please explain:

Have you ever had your hearing tested by any of the following? If yes, please provide the following and attach copies of the hearing test(s).

			Date	Name of Facility	Address/Telephone Number
Audiologist	☐ Yes	☐ No			
Hearing Aid Practitioner	☐ Yes	☐ No			
Physician	☐ Yes	☐ No			
ENT Specialist	☐ Yes	☐ No			
Employer?	☐ Yes	☐ No			
Other? (Specify)	☐ Yes	☐ No			

Do you or have you ever worn a hearing aid? If yes, ☐ Right ☐ Left ☐ Both also, name of supplier and dates of purchase.

Date	Type of Hearing Aid	Name of Facility	Address/Telephone Number

Do you experience ringing or other noises in your ears? ☐ Yes ☐ No If yes, which ear? ☐ Right ☐ Left ☐ Both

If yes, is the noise ☐ Constant? ☐ Intermittent? If yes, when did it begin? *(Year / Month / Day)*

Claimant's *Surname*	*First Name*	*Initial*	WCB Claim Number

Have you experienced any of the following? ☐ Yes ☐ No If yes, please provide date, specific names, and addresses of facility where treatment was sought

	Left	Right	Both	Date	Name of Facility	Address/Telephone Number
Dizziness/balance problems	☐	☐	☐			
Ear Infection	☐	☐	☐			
Ear Pain	☐	☐	☐			
Ear Pressure/Fullness	☐	☐	☐			
Ear Surgery	☐	☐	☐			
Other? (Specify)	☐	☐	☐			

If you are currently experiencing any of the above problems and have not sought medical treatment, we would advise that you do so. Please notify us of the physician's name and date of appointment.

Is there a history of deafness or ear disease in your immediate or extended family? ☐ Yes ☐ No
If yes,please supply the following information:

Relationship of Family Member	Cause of Hearing Loss	Approximate age of diagnosis

Do you or have you had any medical problems for which you take medication on a regular basis? ☐ Yes ☐ No
If yes,please provide the following information:

Medication	From:	To:	Condition	Physician/Facility	Address/Telephone number

MEDICAL HISTORY

Have you experienced any of the following? If yes, please provide date, specific names, and addresses of facility where treatment was sought:

	Yes	No	Date	Name of Facility	Address/Telephone Number
Congenital/facial deformities eg. cleft palate, atresia	☐	☐			
Cancer	☐	☐			
Diabetes	☐	☐			
Heart disease/Heart attack	☐	☐			
High blood pressure	☐	☐			
Intravenous (IV) antibiotics	☐	☐			
Kidney problems	☐	☐			
Serious illness (meningitis, CNV lyme disease, measles, AIDS)	☐	☐			
Severe head injury	☐	☐			
Stroke	☐	☐			
Sudden intense noise (eg. explosion)	☐	☐			
Thyroid Problem?	☐	☐			
Whiplash	☐	☐			
Other? (Specify) _____	☐	☐			

If you are currently experiencing any of the above problems and have not sought medical treatment, we would advise that you do so. Please notify us of the physician's name and date of appointment.

Claimant's *Surname*	*First Name*	*Initial*	WCB Claim Number

RECREATIONAL EXPOSURE

Have you been exposed to any of the following outside of your work?

Source of noise	Yes	No	Number of Years	Type of hearing protection, if used
Amplified music	☐	☐		
Car racing	☐	☐		
Chain saw	☐	☐		
Motorcycle	☐	☐		
Power boat	☐	☐		
Power tools	☐	☐		
Small/prop airplane	☐	☐		
Snowmobile	☐	☐		
Other? (Specify) _____	☐	☐		

FARMING EXPOSURE

Have you worked on a farm? ☐ Yes ☐ No Type of farming: ☐ Grain ☐ Mixed ☐ Livestock, specify (i.e. dairy, beef, pigs) _____

What was the size of the farm? (section/acres) _____ If yes, were you self employed? ☐ Yes ☐ No

WCB Coverage? ☐ Yes ☐ No WCB Account Number: _____ Company Name: _____

Were you employed by a company or corporation? (e.g. ABC Farms Ltd.)

If yes, please supply the Company Name: _____

Address: _____

Did you operate farm machinery? ☐ Yes ☐ No

If yes, please supply the following:

Dates (mm/yy) From:	To:	Equipment Used	Did equipment have a cab? Yes	No	Type of Hearing Protection, if used
			☐	☐	
			☐	☐	
			☐	☐	
			☐	☐	
			☐	☐	

FIREARM EXPOSURE

Have you ever been exposed to firearms? ☐ Yes ☐ No

If yes, shoulder shot from? ☐ Left ☐ Right

Was the shooting for: ☐ Firing Range ☐ Target/trap/skeet shooting ☐ Armed Forces ☐ Work

Please supply the following information regarding firearm use:

Type of Firearm	Calibre	Shots/Year	From:	To:	Reason for use (work, hunting, recreation, etc.)	Type of Hearing Protection, if used

Claimant's *Surname*	*First Name*	*Initial*	WCB Claim Number

MILITARY EXPOSURE

Have you served in the Armed Forces? ☐ Yes ☐ No If yes, please supply the following information:

Department of Armed Forces	Occupation	Dates From:	To:	Source of Noise	Type of Hearing Protection, if used

If you served in the Canadian Military please complete and return the attached Armed Forces Release on page 6.

Declaration and Consent

I declare that the information provided by me on this questionnaire to be true and correct.

I understand that:

My social insurance number may be disclosed to past/present employers in order to confirm my employment history

WCB-Alberta may collect information that it considers relevant to determine benefit entitlement, including information pre-dating my accident, from any source including physicians, other health care providers, employer(s) and vocational rehabilitation service providers.

This information is collected to determine my entitlement to compensation under the Workers' Compensation Act.

WCB-Alberta may use and disclose the information collected to determine entitlement, to provide services and benefits and, as required or authorized by law. This information may be used and disclosed pursuant to the Workers' Compensation Act and the Freedom of Information and Protection of Privacy Act.

Signature

Date *(yy/mm/dd)*

Social Insurance #:

Signing the above consent enables the Workers' Compensation Board to process your claim.

The personal information on this form is being collected in compliance with sections 33(a) & (c) of the Freedom of Information and Protection of Privacy (FOIP) Act and will be used for the purpose of adjudicating your hearing loss claim. The information will be treated in accordance with the privacy protection provisions of Part 2 of the FOIP Act.

ARMED FORCES RELEASE

When did you serve in the Armed forces. From ____ To ____ (yy/mm/dd)

In what trade? _____ Service number _____

Medical Pension? ☐ Yes ☐ No For hearing / ear related problem? ☐ Yes ☐ No

If you served in the Armed Forces, you may wish to pursue a claim through the Bureau of Pension Advocates at your nearest federal Government Branch. (Consult your telephone book for the address).

In view of your service in the Armed Forces, we will be requesting specific employment information in regards to your hearing loss claim.
In order to do so, we must have you sign, date, and return the following Release Form to our office.

To: ATIP and Personnel Records Division
Library and Archives Canada
395 Wellington St.
Ottawa ON K1A 0N4

I hereby authorize the National Personnel Records Centre, Public Archives Canada, to disclose any personal and/or documentary information about me contained in the files held in their custody, to:

Workers' Compensation Board of Alberta
P.O. Box 2415, 9912 - 107 Street
Edmonton AB T5J 2S5

_____ ____
Signature and regimental number of ex-serviceperson Date *(yy/mm/dd)*

wcb Workers' Compensation Board – Alberta

Box 2415
Edmonton AB T5J 2S5
Fax 780-427-5863

C139
EMPLOYER'S INFORMATION QUESTIONNAIRE

To be completed by the employer only

			Claim Number:	
Worker's: *(Surname)*	*(Given)*	*(Initials)*	Date of Birth *(Year / Month / Day)*	
Address: *Street*	*City/Town*	*Province*	Postal Code:	
Telephone Number:	Social Insurance #:		Occupation	
Company Name (as supplied by worker)	Date of Employment from *(Year / Month / Day)*		to *(Year / Month / Day)*	

EMPLOYMENT HISTORY

1. Please confirm and/or correct dates of employment, province employed in and occupations as stated above:

FROM *(Year / Month / Day)*	TO *(Year / Month / Day)*	OCCUPATION	PROVINCE

2. We are unable to confirm employment as stated above for one of the following reasons: *(Please check appropriate box)*

☐ We have no personnel files dating back beyond this date: _____

☐ The company has changed ownership as of _____ and you may contact the former owner, _____

at this phone number, (address) _____

☐ We have searched our records and spoken to long time employees. We have been unable to confirm this claimant's employment with us.

☐ Other *(Please explain)* _____

SAFETY PRECAUTIONS

Was hearing protection provided? ☐ Yes ☐ No

Did you have a policy which required or enforced the use of hearing protection? ☐ Yes ☐ No

HEARING ASSESSMENTS *(Check appropriate box and complete.)*

☐ Audiograms have been taken and **all copies are attached.**

☐ Audiograms have been taken and copies can be obtained from: _____ Name _____ Telephone Number

☐ Hearing assessments have not been completed for our employees.

Worker's: *(Surname)*	*(Given)*	*(Initials)*	Claim Number:

HEARING ASSESSMENTS Continued *(Check appropriate box and complete.)*

☐ Any additional comments you wish to provide would be appreciated. e.g. any pre-existing problems, any knowledge of traumatic injury, etc.

NOISE LEVEL READINGS *(Check appropriate box and complete.)*

Noise level readings have been taken and **copies are attached.**

Noise level readings have been taken and you may obtain them from: _____ Name _____ Telephone Number

Noise level readings have not been taken.

List the equipment, tools, machinery, etc. that the worker would have used or would be located near the work area.

We wish to thank you for your time in providing this information.

Name of Company: _____ Telephone Number: _____

Name of Person Completing Form *(Please Print)* _____

Signature: _____ Date *(yy/mm/dd)*

Position: _____

wcb Workers' Compensation Board – Alberta

Box 2415
Edmonton AB T5J 2S5
Fax (780) 427-5863
1-800-661-1993

C131
WORKER'S EMPLOYMENT RECORD NOISE INDUCED HEARING LOSS CLAIM

WCB Claim Number

Worker's *Surname* *First Name* *Initial*

Address: *Street* *City/Town* *Province* Postal Code: Telephone Number:

Page Of

Please type or print clearly in dark (black) ink.

INSTRUCTIONS

1. *List all employers and military service duties from the time you left school. Show all job categories held and length of time in each.*
2. *In completing this form, start with your first employment and proceed to your most recent employment.*
3. ***Please complete this form even if submitting a record of employment from CPP***

Year and Month you left school *(Year / Month)*

If retired, Date of retirement *(Year / Month / Day)*

If no longer a resident of Alberta, date you left this province *(Year / Month / Day)*

Employer's Complete Name	Province of Employment	Employment Dates From	Employment Dates To	Job Position & Description of Job Duties	Sources of Noise Exposure	Duration of Noise Exposure (Hours per Day / Week / Month)	Type of Hearing Protection Used
		From	To			Day Week Month	
		From	To			Day Week Month	
		From	To			Day Week Month	
		From	To			Day Week Month	
		From	To			Day Week Month	

Worker's *Surname*	*First Name*	*Initial*	WCB Claim Number
			Page Of

Employer's Complete Name	Province of Employment	Employment Dates (Month/Year)		Job Position & Description of Job Duties	Sources of Noise Exposure	Duration of Noise Exposure (Hours per Day / Week / Month)	Type of Hearing Protection Used
		From	To			Day Week Month	
		From	To			Day Week Month	
		From	To			Day Week Month	
		From	To			Day Week Month	
		From	To			Day Week Month	
		From	To			Day Week Month	
		From	To			Day Week Month	
		From	To			Day Week Month	
		From	To			Day Week Month	
		From	To			Day Week Month	

Worker's *Surname*	*First Name*	*Initial*	WCB Claim Number
			Page Of

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		From	To			Day Week Month	
		From	To			Day Week Month	
		From	To			Day Week Month	
		From	To			Day Week Month	
		From	To			Day Week Month	
		From	To			Day Week Month	
		From	To			Day Week Month	
		From	To			Day Week Month	
		From	To			Day Week Month	
		From	To			Day Week Month	

Service Canada
Contributor Client Services
Canada Pension Plan
PO Box 818 Station Main
Winnipeg MB R3C 2N4

After completing form, mail to Service Canada

I am pursuing a claim for noise-induced hearing loss with the Alberta Workers' Compensation Board (WCB). They require confirmation of my complete employment history.

Please provide the following:

- Name of employers
- City/Province
- Years worked at each employer

Earnings and contributions information is not required.

The following information is provided to assist in the retrieval of my employment records. My mailing address is noted below.

I thank you in advance for your prompt reply to my request.

Name: _____

Date of Birth: _____

Social Insurance Number: _____

Signature: _____ Date: _____

Mailing Address: _____

_____

_____