CNESST

APPENDIX TO THE WORKER'S CLAIM
OCCUPATIONAL DISEASE – HEARING IMPAIRMENT
Occupational health and safety

How to fill out the form

You should fill out this form if you believe that you suffer from a hearing impairment caused by your work.

This form contains specific and important questions necessary for considering your claim for an occupational disease. It must be sent to the office of the Commission des normes, de l'équité, de la santé et de la sécurité du travail (CNESST) at the same time as the *Worker's Claim* form, unless you have already sent it to us. You must also send the duly signed Authorization to Disclose Information – Retraite Québec and, if applicable to your situation, the Authorization to Disclose Information – Commission de la construction du Québec.

You **must** enter your health insurance number on this form. If you require assistance in filling out this form, contact the CNESST at 1 844 838-0808.

Regarding your employment history:

- **Indicate the name and address of all employers in whose establishments you assume you contracted your disease, beginning with your current or most recent employer;**
- **If you require more space, use a separate sheet or fill out another form.**

Information disclosure authorizations

During the processing of your claim, information about the jobs you have held may be required to determine eligibility and to charge the cost of benefits to employers for whom you have done work that could result in an occupational disease.

The CNESST requests your authorization to obtain this information from Retraite Québec and/or the Commission de la construction du Québec.

You can give your authorization by filling out the attached authorizations to disclose information.

It is extremely important that you send us all pertinent information related to your claim. Use the section entitled *Comments* or attach another document if necessary. We recommend that you keep a photocopy of this form.

Protection of personal information

We wish to assure you that, in accordance with section 65 of the *Act respecting Access to documents held by public bodies and the Protection of personal information*, the CNESST will treat all information gathered on this form and all information subsequently added to your file as strictly confidential and will make it available only to persons designated in the Declaration of Personal Information Files, which you can consult at the Commission d'accès à l'information. However, some information may be disclosed or obtained without your consent under specific exceptions in the *Act respecting industrial accidents and occupational diseases*, or under agreements between various bodies as provided in the *Act respecting Access to documents held by public bodies and the Protection of personal information*.

All the information requested is necessary for processing your claim. If you refuse to provide this information, your claim could be rejected.

Also, please note that rights of access and rectification are provided in sections 83, 85 and 89-93 of the *Act respecting Access to documents held by public bodies and the Protection of personal information*. To obtain your file, contact your CNESST regional office. If necessary, you can send a request to the person in charge of access to documents and the protection of personal information at the CNESST.

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Worker's file no.

Health insurance no.

Date of event Y Y Y Y M M D D

A. Identification of worker

Surname (as shown on birth certificate)	First name

B. Employment history (list of jobs that, in your opinion, contributed to the development of your hearing impairment)

Are you retired? ☐ **Yes** ☐ **No** **If yes, since when?** _____

Current job (or last job held)

From	Year	Month	Day	To	Year	Month	Day	Job or position

Employer's name (business name)

Address of the establishment to which you are attached | Number | Street | Suite

City | Province | Country | Postal code

Describe the sources of noise in your work environment (your duties, the tools or machinery used in your job, impact noise, other sources of noise in your work environment, etc.).

Detail the duration of exposure to tasks that, in your opinion, contributed to the development of your hearing impairment. For each task, indicate the number of hours per day, the number of days per week, the number of weeks per year and the number of years.

Have any noise reduction measures been taken in your work environment?

☐ Yes (indicate the year) _____ ☐ No ☐ I don't know

If there are any indicators confirming your statement that the work environment was noisy, please identify them (posters, indicator lights, data sheets for work equipment, the need to wear hearing protectors, difficulty having a conversation at a distance of 1 metre, etc.).

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Former job

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C. Information related to your hearing impairment

Was your hearing loss progressive?

☐ **Yes** ☐ **No**

Have you consulted a physician, audiologist, etc., regarding your hearing impairment?

☐ **Yes** ☐ **No** **If yes, please write the name and address of those persons, their specialty, and the approximate date of the consultation.**

1

Name | Specialty | Y Y Y Y M M D D

Address | Number | Street | Suite

City | Province | Country | Postal code

2

Name | Specialty | Y Y Y Y M M D D

Address | Number | Street | Suite

City | Province | Country | Postal code

3

Name | Specialty | Y Y Y Y M M D D

Address | Number | Street | Suite

City | Province | Country | Postal code

4

Name | Specialty | Y Y Y Y M M D D

Address | Number | Street | Suite

City | Province | Country | Postal code

5

Name | Specialty | Y Y Y Y M M D D

Address | Number | Street | Suite

City | Province | Country | Postal code

Have you had one or more audiograms? ☐ Yes ☐ No

If yes, indicate the year or years. _____

Do you wear a hearing aid? ☐ Yes ☐ No

If yes, for how long and in which ear?

When was the first hearing aid prescribed?

By whom (name of health professional and/or audiologist)?

When did you learn of the probable link between your work and your hearing impairment (month and year)?

Note: If you need more space, please use section D, *Comments*.

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D. Comments

Please provide all other information that you consider pertinent to processing your claim and that could be related to your hearing impairment.

E. Signature

I declare that the above information is complete and accurate. Anyone who makes a false statement is guilty of an offence and is liable to a fine.	Worker's signature Y Y Y Y M M D D

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INFORMATION DISCLOSURE AUTHORIZATION

RETRAITE QUÉBEC

Occupational Health and Safety

Dear Sir/Madam,

I hereby authorize Retraite Québec to send the Commission des normes, de l'équité, de la santé et de la sécurité du travail (CNESST) the following information, which appears in the record of contributors:

1. The list of employers (company name and Québec enterprise number) I worked for.
2. The years I worked for each of these employers.

This information concerns the employment injury claim I filed with the CNESST.

This information is required by the CNESST to analyze my claim or to charge the cost of benefits to employers for whom I have done work that may have resulted in my occupational disease.

Surname	First name
Date of birth (Y Y Y Y) (M M) (D D)	Social insurance no.

Signature

Date

CNESST

INFORMATION DISCLOSURE AUTHORIZATION

COMMISSION DE LA CONSTRUCTION DU QUÉBEC

Occupational Health and Safety

Dear Sir/Madam,

I hereby authorize the Commission de la construction du Québec to send the Commission des normes, de l'équité, de la santé et de la sécurité du travail (CNESST) the information contained in my "*Record of hours worked in the construction industry.*"

This information concerns the employment injury claim I filed with the CNESST.

This information is required by the CNESST to analyze my claim or to charge the cost of benefits to employers for whom I have done work that may have resulted in my occupational disease.

Surname	First name
Date of birth (Y Y Y Y) (M M) (D D)	CCQ client number

Signature

Date