WCB Workers Compensation Board of Manitoba

Phone 204-954-4321
(Toll free 1-855-954-4321)
333 Broadway, Winnipeg R3C 4W3
wcb.mb.ca

Employer Hearing Loss Report

Claim Number	EHL

Employer Information

Business Name		Address	Firm Number
City	Province	Postal Code	Phone Number
Type of Business		Location of Plant or Project	

Worker Information

Last Name		First Name	
Address			Phone Number
City	Province	Postal Code	Date of Birth (DD/MM/YYYY)
Social Insurance Number	Gender	Job Title	

Injury Details

1. Has the worker reported any hearing difficulties to your company? ☐ Yes ☐ No
   If yes, when was it first reported? DD-MM-YYYY
   To whom was it reported?

2. a. Did the worker relate any hearing loss to employment with your company? ☐ Yes ☐ No
   b. Was it ascribed to any particular part of the work of the workplace? ☐ Yes ☐ No
   If yes, please explain:

   c. Was a pre-placement audiogram conducted? ☐ Yes ☐ No
   If yes, please submit a copy.

3. Did the worker indicate any other employment elsewhere as a possible source of hearing loss? ☐ Yes ☐ No
   If yes, please explain:

4. What date did the worker begin employment with your firm? (DD/MM/YYYY)
   Was the worker employed by your company previously? ☐ Yes ☐ No
   If yes, when?

5. a. Is the worker still employed with your company? ☐ Yes ☐ No
   If yes, in what capacity?
   If no, date terminated? (DD/MM/YYYY)
   b. Was a post-employment audiogram conducted? ☐ Yes ☐ No
   If yes, please submit a copy.

6. State occupations or job assignments worked at while with your firm and for how long in each duty:

Occupation or Job Title	Period of Employment		Occupation and Proximity to Noise	Type of Machinery or Equipment Used	Exposure to Loud Noise (Hours per day)
	From	To			

Claim Number | EHL

7. Was possible exposure to noise continuous? ☐ Yes ☐ No
   Intermittent? ☐ Yes ☐ No
   Please explain:

8. a. Was the worker issued any protective hearing device? ☐ Yes ☐ No
   If yes, please specify the type of device, the manufacturer and the model number:

   b. Did the worker wear the device regularly? ☐ Yes ☐ No
   c. Hearing protection program implemented? ☐ Yes ☐ No
   If yes, when did it start? (DD/MM/YYYY)
   d. Was the worker properly instructed in use? ☐ Yes ☐ No

9. Has any noise level test or decibel reading been performed in the areas in which this worker was employed? ☐ Yes ☐ No
   If yes, please forward the results, noting what agency/individual conducted this testing:

10. Do you have any medical records which would be helpful in evaluating this worker's past hearing condition?

11. Please provide the name(s) and WCB claim numbers for any other employees who may have had similar hearing problems in the areas where this worker was employed.

12. To your knowledge, does the worker participate in any other outside activity which may have some effect on this present hearing difficulty? ☐ Yes ☐ No
   If yes, please explain.

13. Was the worker ever exposed to a high blast explosion? ☐ Yes ☐ No
   If yes, please provide details, including date:

If the worker is still employed by your company, please answer these additional questions:

14. Is the worker related to the employer, and were they residing in the same household at the time of the injury? ☐ Yes ☐ No

15. Is the worker a partner, director, or other officer of the company? ☐ Yes ☐ No
   If yes, please specify:

Name and Position of Person Completing Report

Date (DD/MM/YYYY)

Fax this form: in Winnipeg: 204-954-4999 | Toll free 1-855-872-3804