

Harvester's Name: _____

4. a) Name of doctor or nurse			
b) Which hospital or nursing station did you go to, if any?	When?	YY	MM DD
c) If your teeth were injured, give name of dentist			
5. a) Have you had a similar disability before? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes - explain			
b) Have you had previous claims with the WSCC? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes - give dates and nature of injury			
6. a) Are you back at harvesting activities? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes - give date you returned to harvesting			
b) If no, when do you think you will be able to return to harvesting? Provide the date you should be able to return YY MM DD			
c) If you harvested since you were hurt provide the dates you harvested From YY MM DD To YY MM DD			
7. In the twelve months before the incident, what other employment earning or income did you receive?			
Name of Company	From	YY MM DD	To YY MM DD Total Earnings
Name of Company	From	YY MM DD	To YY MM DD Total Earnings
Name of Company	From	YY MM DD	To YY MM DD Total Earnings
8. Amount of income from harvested renewable resources (i.e. sales of wild meat, fish, fur sales, etc.)			
	From	YY MM DD	To YY MM DD Total Earnings
9. Additional information or comments			

WORKER'S CONSENT

I hereby claim compensation for work-related injuries or disease.

Information Sharing- I understand that the above information about me will be used by the WSCC for the sole purpose of conducting an investigation into this claim. I also understand that the WSCC will need to gather more information about my work incident and medical and work history to administer my claim. For that specific purpose only, some personal information may have to be disclosed 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 that incomplete information from me may delay my claim, and that 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.

Signed at _____ Date _____ Signature _____

Any personal information, as defined by the *Access to Information and Protection of Privacy Act* (ATIP), requested herein is for the purpose of administering the *Workers' Compensation Act* and is authorized by the Act.

For more information, please contact the WSCC ATIP Co-ordinator at 1-800-661-0792 or 1-867-920-3888.

For more information on our Legislation and Policies, please visit our Website
www.wcb.nt.ca • www.wcbnunavut.ca

If you would like assistance filling in this form, or more information, please contact one of our offices listed below

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

Webpage • www.wcb.nt.ca or www.wcbnunavut.ca