

**EMPLOYER'S INFORMATION QUESTIONNAIRE**

To be completed by the employer only

Worker's: (Surname) (Given) (Initials)			Claim Number:		
Social Insurance #:			Occupation		
Date of Birth (Year / Month / Day)			Date of Birth (Year / Month / Day)		
Company Name (as supplied by worker)		Date of from Employment (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 <small>(Year / Month / Day)</small>	TO <small>(Year / Month / Day)</small>	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: \_\_\_\_\_
- Hearing assessments have not been completed for our employees.

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

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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: \_\_\_\_\_

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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.

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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: \_\_\_\_\_

Position: \_\_\_\_\_