NOISE INDUCED HEARING LOSS – FURTHER INFORMATION FORM

Worker Name: Claim number (if known):

Section 1: Employment History

Position

Period of Employment	Start – Finish (mm/yy) –		
Employer Name		Employer ABN	
Employer Location			
Contact Person			
Normal hours per day/week		Type of Employment	Permanent
All Occupations at this Employer	List all roles worker held		
Duties Performed	Types of activities in each role		
Equipment/ Machinery Used	Manufacture year, brand, maintenance records		
Noise Exposure	i.e. did you have to raise your voice, continuous loud noise		
Hearing Tests Conducted	Hearing tests arranged by employer for he worker		
Hearing Protection Offerred/Worn	List the types of hearing protection provided by employer and whether it was worn		
Employment evidence	Submit any relevant copies of payment summaries, tax records, or employment contracts with this form		

Add Additional Position Details

Section 2: Current working status

Employment status		Details	
Currently employed	☐	Employed by:	
Unemployed	☐	Ceased work on:	
		Reason for ceasing work:	
Retired	☐	Retired on:	dd/mm/yyyy
Pension type, if applicable	☐	Type of pension:	Age

Section 3: Other interests

Provide details of non-work related activities where you may have been exposed to noise. For example, motor car racing, shooting, loud music, military service, metal/wood working, go karting etc.

Section 4: Hearing Health

		Details
Are you experiencing symptoms of tinnitus?	☐	Describe your symptoms…
Have you or do you currently suffer from any ear disease, head injury or heart disease?	☐	Describe your condition…
Have you ever used or been supplied with hearing aids?	☐	If yes, who supplied the hearing aids
Do you currently use hearing aids?	☐	If not, why?
Have you ever had any audiograms to measure you hearing?	☐	If yes, please provide a copy of all previous audiograms and any reports, test results
Have you previously made a claim or received compensation for hearing loss and/or tinnitus?	☐	If yes, when did you claim?
Are you taking any medication?	☐	If yes, name of medication and dosage:

Section 5: Medical Authority

I agree that:

1. Any of my health care providers may receive diagnostic reports, medical imaging, records and medical reports relating to my claim for the purpose of writing a report about my injury, medical condition or illness-related issue and
2. My health care providers may provide ReturnToWorkSA or their Claims Agents with information relevant to my work injury, condition or illness and
3. ReturnToWorkSA or their Claims Agents may release my personal contact information to an independent medical examiner for the purpose of an appointment and
4. A photocopy of this medical authority to be used.

Signature of Worker Full Name Date

Section 6: Declaration

1. I acknowledge that it is an offence under section 196 of the Return to Work Act 2014 to make a statement that is false or misleading and declare that the information I have provided is true.

2. I agree to advise my Claims Agent if I become aware of any matter that would change the information I have provided.

Signature of Worker Full Name Date