

# WORKER'S EMPLOYMENT RECORD (CHEMICAL EXPOSURE)

WCB Claim Number

Personal Health Number

Worker's (Surname)	(First Name)	(Initial)	Date of Birth (YYYY/MM/DD)
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**INSTRUCTIONS**

1. In completing this form, start with your first employment and proceed to your most recent employment.
2. Please type or print clearly in dark (black) ink.

Employer's Name and Address <i>(Street Address, Town/City, Province of Operation)</i>	Employment Period	Occupational Job Duties	Name of Irritants(s)/ Chemicals(s) to which you were exposed	Type of Protective Apparel used
1. <hr/> <hr/>	From <hr/> To	<hr/> <hr/>	<hr/> <hr/>	<hr/> <hr/>
2. <hr/> <hr/>	From <hr/> To	<hr/> <hr/>	<hr/> <hr/>	<hr/> <hr/>
3. <hr/> <hr/>	From <hr/> To	<hr/> <hr/>	<hr/> <hr/>	<hr/> <hr/>
4. <hr/> <hr/>	From <hr/> To	<hr/> <hr/>	<hr/> <hr/>	<hr/> <hr/>
5. <hr/> <hr/>	From <hr/> To	<hr/> <hr/>	<hr/> <hr/>	<hr/> <hr/>
6. <hr/> <hr/>	From <hr/> To	<hr/> <hr/>	<hr/> <hr/>	<hr/> <hr/>