

Employer's Repetitive Strain Injury Questionnaire

			WSCC Claim Number:							
Vor	ker Information									
Last Name:			Firs	First Name:						
Mailing Address (include postal code):			Commi	Community:			Telephone (include area code):			
Re	esidential Address:		Date o			Date of	f Birth: YY MM DD			
Er	nployer's Name:		Wor	ker's Occi	upation:				<u> </u>	
Int	roduction									
	e WSCC is in receipt of a claim for ndition. This does not involve a dire							be for a p	rogressive	
Questions				Responses						
1.	Briefly describe main functions of this job:									
2.	Please describe the workplace set-up, including the position of any furniture, fixed tools, etc., that the worker uses.									
3.	Is the workplace hot, cold or normal room temperature?	Hot □ Cold □ Room Temperature □								
4.	Repetitive tasks in worker's job: (Specify on grid)	Task	Weight	Force	R/L/ Both	Hrs./ Day	Cont. Hrs.	Breaks	Vibratory Tools	
	Weight involved with task	1.								
	Force applied to do task	2.								
	· Right or left hand or both	3.								
	Hours per day	4.								
	 Continuous hours performed 	5.								
	 Frequency/length/number of breaks 	6.								
	· Vibratory tools used	7.								
5.	5. Do any of these movements involve: twisting motion; wringing motion; above shoulder level work; gripping motion?	Twisting motion □ Wringing motion □								
		Above shoulder level work □ Gripping motion □								
		Vibrating tools/equipment □ (specify):								
	(Circle and relate to task number above)	Dropping small items		C	other □ (sp	pecify): _				

Questions	Responses							
6. Have there been any recent changes in the type or number of tasks the worker performs? If yes, please specify:								
7. Has/had the worker been doing any overtime or								
extraordinary work? If yes, please specify:								
8. Have there been any changes/ alterations/modifications to the work stations? If yes, when?								
How long has the worker had this current job?								
10. When were the symptom(s) first reported to you?								
11. Describe the difficulties the worker was having in performing the job.								
12. Are other workers aware of this worker's problems at work?								
13. Have you made any accommodations for the worker specifically to assist with this problem? (Hours, workspace, tools, breaks, etc.) If yes, describe:								
14. Are you aware of any	Activity	Frequency						
personal activities, including sports, hobbies, recreation,								
fitness or weight training								
(past or present) this worker participates in?								
Type? How often?								
Any additional information?								
This information will help determine if the claim is work-related in whole or in part. The worker is completing a similar form. Include a copy of the worker's job description with this form.								
Any information received as a result of the claims process is confidential. Further use or disclosure of the information could result in a fine pursuant to the Workers' Compensation Acts.								
Signature of Employer:	Date:	Date:						

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