

***MPP ID No:*** Click here to enter text.

***OHCOW Client No:*** Click here to enter text.

***CLIENT REGISTRATION***

(If the worker is deceased, please use the estate trustee/executor(rix)/administrator of the estate address.)

***GENERAL INFORMATION (please use worker’s name)***

Last Name Click here to enter text. Middle Name: Click here to enter text.

First Name Click here to enter text. Known As: Click here to enter text.

Sex Choose an item. Street Name & # Click here to enter text.

City Click here to enter text. Postal Code Click here to enter text.

Home Telephone Number Click here to enter text.

Work Telephone Number Click here to enter text.

Date of Birth *(D/M/YR))* Click here to enter a date.

Date of Death  *(D/M/YR))* Click here to enter a date.

Birthplace Click here to enter text. Preferred Language Click here to enter text.

Mother’s Maiden Name *(Required by the OH&S Act)* Click here to enter text.

Social Insurance Number Click here to enter text.

Health Card Number Click here to enter text. E-mail Address Click here to enter text.

***DECEASED WORKER***

1. Has an autopsy been performed? Choose an item.
2. If yes, do you have a copy? Choose an item.
3. If yes, where is the information being sent? Choose an item.
4. Are you the estate trustee/executor(rix)/administrator of the estate?

Choose an item.

1. If the answer was ‘Yes’, is there a copy of the will stating who is the estate trustee/executor(rix)/administrator of the estate? Choose an item.
2. Where is the will/letter from lawyer being sent? Choose an item.
3. If there is no will, a letter from a lawyer stating that you are the estate trustee/executor(rix)/administrator of the estate.

***PARTICIPANT INFORMATION***

1. If the worker is not attending the intake clinic, who will participate? Click here to enter text.
2. What is your relation to the worker? Choose an item.
3. Do you have a letter from the trustee/admin/exec authorizing you to act on the behalf of the estate? Choose an item.
4. If you are attending the intake clinic on behalf of the worker, is the worker mentally competent to be contacted? Choose an item.
5. If you are attending the intake clinic on behalf of the worker, do you have written authorization to represent the worker? Choose an item.
6. If yes, where is the information being sent? Choose an item.

***OTHER***

1. Do you know of any other workers who have suffered from neurodegenerative diseases such as Alzheimer’s, Parkinson’s, or ALS who will not be coming to the intake clinic because they have moved away/passed away etc.? Choose an item.

Notes: Click here to enter text.

1. Do you have any documents relevant to staffing and processes at the mines where McIntyre exposures occurred? i.e. handbook, seniority lists, copies of policies or procedures. Choose an item.
2. If yes, where is the information being sent: Choose an item.

Action taken: Click here to enter text.

## UNION INFORMATION

Union Name Click here to enter text. Union Local # Click here to enter text.

Union Representative Click here to enter text. Street Name and # Click here to enter text.

City Click here to enter text. Postal Code Click here to enter text.

Telephone # Click here to enter text. Fax #Click here to enter text.

E-mail Address Click here to enter text.

## EMPLOYER INFORMATION (Current/last employer)

Occupation Click here to enter text. Industry Click here to enter text.

Employer Click here to enter text.

Address Click here to enter text. City Click here to enter text.

Postal Code Click here to enter text.

Telephone Number Click here to enter text. E-mail Address Click here to enter text.

Date of Hire *(D/M/YR))* Click here to enter a date. Last Day Worked *(D/M/YR))* Click here to enter a date.

1. Do you know the miner’s certificate number? Choose an item..
2. If yes, what is the number? Click here to enter text.
3. Do you have the mining master record? Choose an item.
4. Do you have the Ontario Respiratory Film service (ORF file)? Choose an item.

***FAMILY PHYSICIAN***

Name Click here to enter text. Address Click here to enter text.

City Click here to enter text.

Postal Code Click here to enter text. Telephone Number Click here to enter a date.

Fax Number Click here to enter a date. E-mail Address Click here to enter a date.

***SPECIALIST***

1. Name Click here to enter text. Address Click here to enter text.

City Click here to enter text. Postal Code Click here to enter text. Telephone Number Click here to enter a date.

Fax Number Click here to enter a date. E-mail Address Click here to enter a date.

1. Name Click here to enter text. Address Click here to enter text.

City Click here to enter text. Postal Code Click here to enter text.

Telephone Number Click here to enter a date.

Fax Number Click here to enter a date. E-mail Address Click here to enter a date.

## Medical Information

1. If you have not put forth a WSIB claim related to McIntyre powder exposure, do you have a copy of medical information related to the exposure? Choose an item.
2. (If there is a claim, all of the medical information will be in the WSIB claim file)
3. If yes, where is this information being sent? Choose an item.
4. If no, please contact your physician for the medical information pertaining to the exposure.

Action taken: Click here to enter text. Click here to enter a date.

## INTAKE CLINIC

1. On what day does the worker/ estate trustee/executor(rix)/administrator of the estate plan on attending the intake clinic? Choose an item.
2. What time does the worker/estate trustee/executor(rix)/administrator of the estate plan on attending the clinic? Choose an item.

Notes: Click here to enter text.

## WSIB

1. Are there any WSIB claims related to the McIntyre dust exposure? Choose an item.
2. Was the claim successful? Choose an item.
3. If the claim was not successful, do you have a copy of the claim(s)? Choose an item.
4. If yes, where is the claim file(s) being sent: Choose an item.
5. If no, contact WSIB directly (1-800-387-0750) to request a copy of the WSIB claim file under the Freedom of Information Act. Or go to: <http://www.wsib.on.ca/cs/idcplg?IdcService=GET_FILE&dDocName=WSIB012701&RevisionSelectionMethod=LatestReleased> and fill in the form and send/fax to WSIB. Address is on the top of the form.
6. Do you have any other WSIB claims? Choose an item.
7. If you do have other WSIB claims, what are the claim number(s)? Click here to enter text.

Note: We do not require copies at this time.

Action taken: Click here to enter a date.

Notes: Click here to enter text.

***Consent***

Deceased worker? Choose an item. OHCOW Choose an item.

Media Choose an item. USW Choose an item.

Other representative Click here to enter text.

If yes, where are the consents being sent? Choose an item.

The consents were sent out to the worker on: Click here to enter a date.

***WORK HISTORY***

|  |  |  |  |
| --- | --- | --- | --- |
| **Employer and City** | **Years Employed** | **Position** | **Union** |
| *Example:*  *ABC Company* | *1976-1987* | *Labourer* | *USW L7689* |
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***HISTORY OF PLACES OF RESIDENCE***

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| --- | --- | --- | --- |
| **Approximate start date at residence** | **Approximate end date at residence** | **Town** | **Source of water (well or town)** |
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