Disease investigation form

Name	Next of Kin *(if employee deceased)*
Address	Telephone
City/Province	Compensation Number
Postal Code	Date of first employment
Work history	
Jobs worked	
Description	
Date worked	
Length of shifts or overtime	
Disease history	
Diagnosis or cause of death	
Other diseases, conditions, or complications identified	
Date of first diagnosis	
Date of death	Attach any certificate of death, autopsy report, medical opinions received from employee or next of kin.
Treatment provided	
Cause or causes of the disease	
Attached hazard information	
☐ Block diagram of workplace	☐ Process flowchart
☐ Exposure records	☐ Ergonomic report/survey
☐ Workplace surveys/questionnaires	☐ Safe work procedure
☐ Material Safety Data Sheet	☐ Other

Disease investigation form 2

Names of any employees willing to describe relevant conditions.
1.
2.
3.
4.
5.
Names of other employees suffering from the same disease or a disease related to the same source.
1.
2.
3.
4.
5.

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Additional notes: