



Occupational Disease & Employment History

Name	Claim Number
------	--------------

Occupational Disease History

What is the medical condition for which you are filing this claim?	What symptoms do you have?	When did you first notice you had these symptoms?	Month / Year
When were you first told by a doctor that your symptoms were caused by your job? Month / Year	Have you ever seen any other doctor for these symptoms?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	Have you ever had any medical tests for these symptoms?		<input type="checkbox"/> Yes <input type="checkbox"/> No
Name of doctor who told you that your symptoms are related to your job: (print or type)			
Address City State ZIP+4			
Please complete the attached medical records release forms so that we can obtain your records. Is your completed release attached? <input type="checkbox"/> Yes <input type="checkbox"/> No		If the release is not completed, your claim for benefits will be delayed or may be rejected.	
Type of work you perform that you believe caused your symptoms:		Start date of employment at the first job you think caused your symptoms. Month / Year	
What activity did you perform at work that you believe caused your symptoms? (Please check all that apply)			
<input type="checkbox"/> Gripping or Pinching <input type="checkbox"/> Pulling <input type="checkbox"/> Kneeling <input type="checkbox"/> Tools used _____ <input type="checkbox"/> Forceful activity <input type="checkbox"/> Pushing <input type="checkbox"/> Reaching overhead <input type="checkbox"/> Twisting with my _____ <input type="checkbox"/> Repetitive tasks (describe) _____ <input type="checkbox"/> Other (describe) _____			

Employment History

Please start with your most RECENT job and work BACKWARDS. Include all current and past employment. All dates should be your best estimate. You must list any breaks or interruptions in your work history.

Employer's business name	Your job title	Employment Dates:	From (mo/yr) To (mo/yr)
Employer's address		Employer's phone number	
City State ZIP+4		How many hours per week did you perform the activity you believe caused your symptoms? _____ hours	
Describe the job duties, tool use or repetitive activities done on a regular basis. Include approximately how much time per day you spent doing each activity			
Indicate any break or interruption in your work history during this job or between this job and the next.		From (mo/yr)	To (mo/yr)
Reason for interruption:			

Employer's business name	Your job title	Employment Dates:	From (mo/yr) To (mo/yr)
Employer's address		Employer's phone number	
City State ZIP+4		How many hours per week did you perform the activity you believe caused your symptoms? _____ hours	
Describe the job duties, tool use or repetitive activities done on a regular basis. Include approximately how much time per day you spent doing each activity			
Indicate any break or interruption in your work history during this job or between this job and the next.		From (mo/yr)	To (mo/yr)
Reason for interruption:			

I certify that the information is true and correct to the best of my knowledge.

Page 1 of _____ Date: _____ Signature: _____