



Chemical Exposure Questionnaire

Claimant' Name		Injury Date	Claim Number
Claimant's address			
Claimant's Phone Numbers			
Home	Cell	Alternate Phone #	If not your phone, Name and Relationship

Have you applied for Longshore or FECA benefits? <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, Please provide the federal claim number:
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Military Service

Have you had military service? <input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, please provide your dates of service	
	From	To
Military Job Title		
Military Job Duties		
Were you exposed to any chemical or other irritants or fumes while in the military? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, describe the source and how exposed. If you received medical treatment for the exposure, please state where:		

Non-Work Chemical Exposure

Do you have any hobbies or non-work activities that exposed you to irritants or fumes? <input type="checkbox"/> Yes <input type="checkbox"/> No If Yes, please describe			
Have you ever smoked? <input type="checkbox"/> Yes <input type="checkbox"/> No Check all that apply <input type="checkbox"/> Cigar <input type="checkbox"/> Cigarettes <input type="checkbox"/> Pipe <input type="checkbox"/> Other			
From	To	Amount smoked per day	Total number of years
Please list any other hobbies or activities that you participate in:			
Have there been any recent changes around your household, e.g. cleaning agents, new carpet, remodeling, pets, pesticide use, etc. If so, please explain:			

Please list all medical conditions and medications prior to filing this claim.

Medical Condition	Medication?	Name of medications
	Yes <input type="checkbox"/> No <input type="checkbox"/>	
	Yes <input type="checkbox"/> No <input type="checkbox"/>	
	Yes <input type="checkbox"/> No <input type="checkbox"/>	
	Yes <input type="checkbox"/> No <input type="checkbox"/>	
	Yes <input type="checkbox"/> No <input type="checkbox"/>	
	Yes <input type="checkbox"/> No <input type="checkbox"/>	
	Yes <input type="checkbox"/> No <input type="checkbox"/>	
	Yes <input type="checkbox"/> No <input type="checkbox"/>	
	Yes <input type="checkbox"/> No <input type="checkbox"/>	
	Yes <input type="checkbox"/> No <input type="checkbox"/>	
	Yes <input type="checkbox"/> No <input type="checkbox"/>	
	Yes <input type="checkbox"/> No <input type="checkbox"/>	
	Yes <input type="checkbox"/> No <input type="checkbox"/>	
	Yes <input type="checkbox"/> No <input type="checkbox"/>	
	Yes <input type="checkbox"/> No <input type="checkbox"/>	
	Yes <input type="checkbox"/> No <input type="checkbox"/>	
	Yes <input type="checkbox"/> No <input type="checkbox"/>	

Please list all non-prescription medications or supplements currently taking

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Previously Filed Occupational Exposure Claims

Claim #	State Filed	Type of exposure

Chemical Exposure 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	
State earned income for last employer where exposure occurred	Hourly	Monthly Yearly

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.

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 and how it contributed to your chemical exposure. Include approximately how much time per day you spent doing each activity				
Do you believe that this exposure contributed to your current condition? Yes <input type="checkbox"/> No <input type="checkbox"/>				
Have you used any protective equipment or clothing while exposed? Yes <input type="checkbox"/> No <input type="checkbox"/> If Yes, list the equipment used:				

Employer's business name	Your job title	Employment Dates:	From (mo/yr)	To (mo/yr)
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Have you used any protective equipment or clothing while exposed? Yes <input type="checkbox"/> No <input type="checkbox"/> If Yes, list the equipment used:		

I declare that my answers are true to the best of my knowledge and belief

Printed Name	Signature	date
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Department of Labor and
Industries
PO Box 44291
Olympia WA 98504-4291



Worker Release for Union Dispatch Records

To Whom It May Concern:

You are hereby authorized to provide the Washington State Department of Labor and Industries with a copy of my Union Dispatch Records.

I understand that Labor and Industries will use this information to evaluate my occupational disease claim for benefits.

I agree that this authorization will remain valid until the conclusion of this claim, unless revoked by me in writing to Labor and Industries.

YOU MAY accept a photocopy of the form as the original.

Signature of Worker or Representative

Date

Social security Number

Date of Birth

Return this form to:
Department of Labor and Industries
PO Box 44291
Olympia WA 98504-4291

If you are asking the Department to obtain your Union Dispatch Records, please provide the following information with your release form:

Names and addresses of all Union halls you have worked for, in or out of Washington State.

Union Hall Name		
Local		
Address		
City	State	Zip Code

Union Hall Name		
Local		
Address		
City	State	Zip Code

Union Hall Name		
Local		
Address		
City	State	Zip Code

Union Hall Name		
Local		
Address		
City	State	Zip Code



Authorization to Release Information

Worker Information:

Worker Name:	Claim Number:
Social Security Number (for ID only):	Date of Birth:

Provider:

Provider Name:

I am authorizing you to give Labor and Industries or its representative any information you may have regarding my condition(s) while your treatment.

In addition to your observations, please include:

- Records of medical history.
- Examinations.
- Consultations.
- X-Ray reports.
- Laboratory studies.
- Operative and pathology reports.
- Physicians' and nurses' notes.
- Hospital records.
- Diagnoses.
- Prescription or treatment information relating to any disease, injury or other physical condition.

Please release all records of treatment for:

Data to be release includes:

- Alcohol abuse Drug abuse HIV/AIDS Psychiatric care

And/or other information protected by federal law.

I understand I am releasing these records so that Labor and Industries can administer and process my claim. I understand these records will be treated confidentially in accordance with state law ([RCW 51.28.070](#)).

This authorization can be withdrawn by me at any time.

Worker Signature _____ Date _____

For your convenience, the address below will appear through a standard window envelope.

Department of Labor and Industries
PO Box 44291
Olympia WA 98504-4291

REQUEST FOR SOCIAL SECURITY EARNINGS INFORMATION

*Use This Form If You Need

1. Certified/Non-Certified Detailed Earnings Information

Includes periods of employment or self-employment and the names and addresses of employers.

OR**2. Certified Yearly Totals of Earnings**

Includes total earnings for each year but does not include the names and addresses of employers.

DO NOT USE THIS FORM TO REQUEST YEARLY EARNINGS TOTALS

Yearly earnings totals are FREE to the public if you do not require certification.

To obtain FREE yearly totals of earnings, visit our website at www.ssa.gov/myaccount.

**Privacy Act Statement
Collection and Use of Personal Information**

Section 205 of the Social Security Act, as amended, authorizes us to collect the information on this form. We will use the information you provide to identify your records and send the earnings information you request. Completion of this form is voluntary; however, failure to do so may prevent your request from being processed.

We rarely use the information in your earnings record for any purpose other than for determining your entitlement to Social Security benefits. However, we may use it for the administration and integrity of Social Security programs. We may also disclose information to another person or to another agency in accordance with approved routine uses, which include but are not limited to the following:

1. To enable a third party or an agency to assist Social Security in establishing rights to Social Security benefits and/or coverage;
2. To comply with Federal laws requiring the release of information from Social Security records (e.g., to the Government Accountability Office and Department of Veterans' Affairs);
3. To make determinations for eligibility in similar health and income maintenance programs at the Federal, State, and local level; and,
4. To facilitate statistical research, audit, or investigative activities necessary to assure the integrity and improvement of Social Security programs.

A complete list of routine uses for earnings information is available in our Systems of Records Notices entitled, the Earnings Recording and Self-Employment Income System (60-0059), the Master Beneficiary Record (60-0090), and the SSA-Initiated Personal Earnings and Benefit Estimate Statement (60-0224).

In addition, you may choose to pay for the earnings information you requested with a credit card. 31 C.F.R. Part 206 specifically authorizes us to collect credit card information. The information you provide about your credit card is voluntary. Providing payment information is only necessary if you are making payment by credit card. You do not need to fill out the credit card information if you choose another means of payment (for example, by check or money order). If you choose the credit card payment option, we will provide the information you give us to the banks handling your credit card account and the Social Security Administration's (SSA) account.

Routine uses applicable to credit card information, include but are not limited to:

(1) to enable a third party or an agency to assist Social Security to effect a salary or an administrative offset or to an agent of SSA that is a consumer reporting agency for preparation of a commercial credit report in accordance with 31 U.S.C. §§ 3711, 3717 and 3718; and (2) to a consumer reporting agency or debt collection agent to aid in the collection of outstanding debts to the Federal Government.

A complete list of routine uses for credit card information is available in our System of Records Notice entitled, the Financial Transactions of SSA Accounting and Finance Offices (60-0231). The notice, additional information regarding this form, routine uses of information, and our programs and systems is available on-line at www.socialsecurity.gov or at your local Social Security office.

Paperwork Reduction Act Statement - This information collection meets the requirements of 44 U.S.C. § 3507, as amended by section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take about 11 minutes to read the instructions, gather the facts, and answer the questions. **Send only comments relating to our time estimate above to:** SSA, 6401 Security Blvd, Baltimore, MD 21235-6401.

REQUEST FOR SOCIAL SECURITY EARNINGS INFORMATION

1. Provide your name as it appears on your most recent Social Security card or the name of the individual whose earnings you are requesting.

First Name:

 Middle Initial:

Last Name:

Social Security Number (SSN)

 -

 -

 One SSN per request

Date of Death:

 /

 /

 Date of Birth:

 /

 /

Other Name(s) Used
(Include Maiden Name)

2. What kind of earnings information do you need? (Choose **ONE** of the following types of earnings or SSA must return this request.)

Itemized Statement of Earnings \$102 Year(s) Requested:

 to

 (Includes the names and addresses of employers) Year(s) Requested:

 to

 If you check this box, tell us why you need this information below.

Check this box if you want the earnings information **CERTIFIED** for an additional \$32.00 fee.

Certified Yearly Totals of Earnings \$32 Year(s) Requested:

 to

 (Does not include the names and addresses of employers) Year(s) Requested:

 to

 Yearly earnings totals are FREE to the public if you do not require certification. To obtain FREE yearly totals of earnings, visit our website at www.ssa.gov/myaccount.

3. If you would like this information **sent to someone else**, please fill in the information below.

I authorize the Social Security Administration to release the earnings information to:

Name Department of Labor and Industries

Address Chemically Related Illness Unit PO Box 44286

State WA

City Olympia WA 98504-4286

ZIP Code see left

4. I am the individual to whom the record pertains (or a person authorized to sign on behalf of that individual). I understand that any false representation to knowingly and willfully obtain information from Social Security records is punishable by a fine of not more than \$5,000 or one year in prison.

Signature of Individual or legal guardian

SSA must receive this form within 60 days from the date signed

Date:

 /

 /

Relationship (if applicable, you must attach proof)

Daytime Phone:

Address

State

City

ZIP Code

Witnesses must sign this form ONLY if the above signature is by marked (X). If signed by mark (X), two witnesses to the signing who know the signee must sign below and provide their full addresses. Please print the signee's name next to the mark (X) on the signature line above.

1. Signature of Witness	2. Signature of Witness
Address (Number and Street, City, State and ZIP Code)	Address (Number and Street, City, State and ZIP Code)

REQUEST FOR SOCIAL SECURITY EARNINGS INFORMATION

INFORMATION ABOUT YOUR REQUEST

You may use this form to request earnings information for **only ONE** Social Security Number (SSN)

How do I get my earnings statement?

You must complete the attached form to tell us the specific years of earnings you want and provide **ONE** mailing address. Mail the completed form to SSA within 60 days of signature. If you sign with an "X", your mark must be witnessed by two impartial persons who must provide their name and address in the spaces provided.

Select **ONE** type of earnings statements and include the appropriate fee.

1. Certified/Non-Certified Itemized Statement of Earnings

This statement includes years of self-employment or employment and the names and addresses of employers.

2. Certified Yearly Totals of Earnings

This statement includes the total earnings for each year requested but *does not* include the names and addresses of employers.

If you require one of each type of earnings statement, you must complete two separate forms. Mail each form to SSA with one form of payment attached to each request.

How do I get someone else's earnings statement?

You may get someone else's earnings information if you meet one of the following criteria, attached the necessary documents to show your entitlement to the earnings information and include the appropriate fee.

1. Someone Else's Earnings

The natural or adoptive parent or legal guardian of a minor child, or the legal guardian of a legally declared incompetent individual, may obtain earnings information if acting in the best interest of the minor child or incompetent individual. You must include proof of your relationship to the individual with your request. The proof may include a birth certificate, court order, adoption decree, or other legally binding document.

2. A Deceased Person's Earnings

You can request earnings information from the record of a deceased person if you are:

- The legal representative of the estate;
- A survivor (that is, the spouse, parent, child, divorced spouse of divorced parent); or
- An individual with a material interest (e.g., financial) who is an heir at law, next of kin, beneficiary under the will or donee of property of the decedent.

You must include proof of death and proof of your relationship to the deceased with your request.

Is There A Fee For Earnings Information?

Yes. We charge a \$102 fee for providing information for purposes unrelated to the administration of our programs.

1. Certified or Non-Certified Itemized Statement of Earnings

In most instances, individuals request itemized statements of earnings for purposes unrelated to our programs such as for a private pension plan or personal injury suit.

Private pension plans may email OCO.Pension.Fund@ssa.gov for an alternate method of obtaining itemized earnings information.

We will **certify** the itemized earnings information for an additional \$32.00 fee. Certification is usually not necessary unless you are specifically requested to obtain a certified earnings record.

Sometimes, there is no charge for itemized earnings information. If you have reason to believe your earnings are not correct (for example, you have previously received earnings information from us and it does not agree with your records), we will supply you with more detail for the year(s) in question. Be sure to show the year(s) involved on the request form and explain why you need the information. If you do not tell us why you need the information, we will charge a fee.

2. Certified Yearly Totals of Earnings

We charge \$32 to certify yearly totals of earnings. However, if you do not want or need certification, you may obtain yearly totals **FREE** of charge at www.ssa.gov/myaccount. Certification is usually not necessary unless you are advised specifically to obtain a certified earnings record.

Method of Payment DO NOT SEND CASH.

You may pay by credit card, check or money order.

• Credit Card Instructions

Complete the credit card section on page 4 and return it with your request form.

• Check or Money Order Instructions

Enclose one check or money order per request form payable to the Social Security Administration and write the Social Security number in the memo.

How long will it take SSA to process my request?

Please allow SSA 120 days to process this request. After 120 days, you may contact 1-800-772-1213 to leave an inquiry regarding your request.

REQUEST FOR SOCIAL SECURITY EARNINGS INFORMATION

• Where do I send my complete request?

Mail the completed form, supporting documentation, and applicable fee to: Social Security Administration Division of Earnings Record Operations P.O. Box 33003 Baltimore, Maryland 21290-3003	If using private contractor such as FedEx mail form, supporting documentation and applicable fee to: Social Security Administration Division of Earnings Record Operations 300 N. Greene St. Baltimore, Maryland 21290-0300
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• How much do I have to pay for an Itemized Statement of Earnings?

Non-Certified Itemized Statement of Earnings	Certified Itemized Statement of Earnings
\$102.00	\$134.00

• How much do I have to pay for certified yearly totals of earnings?

Certified yearly totals of earnings cost \$32.00. You may obtain non-certified yearly totals *FREE* of charge at www.ssa.gov/myaccount. Certification is usually not necessary unless you are specifically asked to obtain a certified earnings record.

YOU CAN MAKE YOUR PAYMENT BY CREDIT CARD

As a convenience, we offer you the option to make your payment by credit card. However, regular credit card rules will apply. You may also pay by check or money order. Make check payable to Social Security Administration.

CHECK ONE	<input type="checkbox"/> Visa <input type="checkbox"/> American Express <input type="checkbox"/> MasterCard <input type="checkbox"/> Discover
Credit Card Holder's Name (Enter the name from the credit card)	_____ First Name, Middle Initial, Last Name
Credit Card Holder's Address	_____ Number & Street _____ City, State, & ZIP Code
Daytime Telephone Number	(<input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/>) <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> - <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <input style="width: 20px; height: 20px;" type="text"/> <small style="margin-left: 100px;">Area Code</small>
Credit Card Number	<input style="width: 20px; height: 20px;" type="text"/> - <input style="width: 20px; height: 20px;" type="text"/> - <input style="width: 20px; height: 20px;" type="text"/>
Credit Card Expiration Date	_____ (MM/YY)
Amount Charged <small>See above to select the correct fee for your request. Applicable fees are \$32, \$102 or \$134. SSA will return forms without the appropriate fee.</small>	\$ _____
Credit Card Holder's Signature	_____

DO NOT WRITE IN THIS SPACE OFFICE USE ONLY	Authorization	
	Name	Date
	Remittance Control #	