West Virginia Workers' Compensation
Physician's Report of Occupational Pneumoconiosis

PLEASE PRINT OR TYPE

Claimant's Name (First, Middle, Last):

Claimant's Address:

City, State, Zip:

Date of Birth:	☐ Male ☐ Female	☐ Single ☐ Married ☐ Widowed	Social Security Number:

Date of first treatment or examination:	Diagnosis:

In your opinion, has claimant contracted occupational pneumoconiosis? ☐ Yes ☐ No

How long has claimant been suffering from the disease of occupational pneumoconiosis?

Has the claimant's capacity for work been impaired by occupational pneumoconiosis? ☐ Yes ☐ No

If yes, to what extent?

History: Has the claimant ever had:

	Yes	No	Date		Yes	No	Date
Pneumonia	☐	☐		Angina Pectoria	☐	☐	
Pleurisy	☐	☐		Coronary Occlusion	☐	☐	
Asthma	☐	☐		Rheumatic Heart Disease	☐	☐	
Tuberculosis	☐	☐		Congestive Heart Failure	☐	☐	
				Arthritis	☐	☐	

Other serious illnesses: ☐ Yes ☐ No	Date and describe:
Surgery: ☐ Yes ☐ No	Date and describe:
Accident: ☐ Yes ☐ No	Date and describe:

Present complaints and duration of complaints:

Has the sputum of the claimant been examined for tubercle bacillus? ☐ Yes ☐ No

If yes, by whom?

What lab?

Findings?

Where are the lab reports filed?

If employee is deceased, was an autopsy performed? ☐ Yes ☐ No

Has claimant participated in any OP treatment program? ☐ Yes ☐ No

Have x-rays been made of the claimant's lungs? ☐ Yes ☐ No

Right lung ☐ Yes ☐ No | Left lung ☐ Yes ☐ No | If yes to either, please answer below:

Hospital or Doctor	Date	Where Filed	Findings

Have pulmonary function studies, blood gas studies or other pertinent clinical examinations been performed?

☐ Yes ☐ No If yes to either, please answer below:

Hospital or Doctor	Date	Where Filed	Findings

Appearance: ☐ Good ☐ Fair ☐ Poor

Height: ft. in.

Weight: lbs. One year ago: lbs.

Breath Sounds: ☐ Normal ☐ Suppressed ☐ Rales ☐ Wheezing

Findings:

Heart: Blood Pressure:

Pulse:

Sounds: ☐ Normal ☐ Abnormal

Murmurs:

Findings:

Other significant physical abnormalities:

Signature
Address
Date

1544192534

DEPARTMENT OF HEALTH AND HUMAN SERVICES
PUBLIC HEALTH SERVICE

OMB No.: 0920-0020

CENTERS FOR DISEASE CONTROL & PREVENTION
National Institute for Occupational Safety and Health
Federal Mine Safety and Health Act of 1977
Medical Examination Program

Coal Workers' Health Surveillance Program
NIOSH
1095 Willowdale Road M/S LB208
Morgantown, West Virginia 26505

DATE OF RADIOGRAPH

MONTH DAY YEAR

WORKER'S Social Security Number

Note: Please record your interpretation of a single film by placing an "x" in the appropriate boxes on this form.

ROENTGENOGRAPHIC INTERPRETATION

TYPE OF READING

A B P

FACILITY IDENTIFICATION

1. FILM QUALITY

1 2 3 U/R

(If not Grade 1, mark all boxes that apply)

Overexposed (dark) | Improper position | Underinflation
Underexposed (light) | Poor contrast | Mottle
Artifacts | Poor processing | Other (please specify)

2A. ANY PARENCHYMAL ABNORMALITIES CONSISTENT WITH PNEUMOCONIOSIS?

YES — Complete Sections 2B and 2C NO — Proceed to Section 3A

2B. SMALL OPACITIES

a. SHAPE/SIZE

PRIMARY: p s q t r u
SECONDARY: p s q t r u

b. ZONES (R L): UPPER, MIDDLE, LOWER

c. PROFUSION

0/- 0/0 0/1
1/0 1/1 1/2
2/1 2/2 2/3
3/2 3/3 3/+

2C. LARGE OPACITIES

SIZE O A B C — Proceed to Section 3A

3A. ANY PLEURAL ABNORMALITIES CONSISTENT WITH PNEUMOCONIOSIS?

YES — Complete Sections 3B, 3C NO — Proceed to Section 4A

3B. PLEURAL PLAQUES *(mark site, calcification, extent, and width)*

Chest wall

	Site	*Calcification*
In profile	O R L	O R L
Face on	O R L	O R L
Diaphragm	O R L	O R L
Other site(s)	O R L	O R L

Extent (chest wall; combined for in profile and face on)
Up to 1/4 of lateral chest wall = 1
1/4 to 1/2 of lateral chest wall = 2
> 1/2 of lateral chest wall = 3

O R — 1 2 3 O L — 1 2 3

Width (in profile only)
(3mm minimum width required)
3 to 5 mm = a
5 to 10 mm = b
> 10 mm = c

O R — a b c O L — a b c

3C. COSTOPHRENIC ANGLE OBLITERATION

R L — Proceed to Section 3D NO — Proceed to Section 4A

3D. DIFFUSE PLEURAL THICKENING *(mark site, calcification, extent, and width)*

Chest wall

	Site	*Calcification*
In profile	O R L	O R L
Face on	O R L	O R L

Extent (chest wall; combined for in profile and face on)
Up to 1/4 of lateral chest wall = 1
1/4 to 1/2 of lateral chest wall = 2
> 1/2 of lateral chest wall = 3

O R — 1 2 3 O L — 1 2 3

Width (in profile only)
(3mm minimum width required)
3 to 5 mm = a
5 to 10 mm = b
> 10 mm = c

O R — a b c O L — a b c

4A. ANY OTHER ABNORMALITIES?

YES — Complete Sections 4B, 4C, 4D, 4E NO — Proceed to Section 5

4B. OTHER SYMBOLS (OBLIGATORY)

aa at ax bu ca cg cn co cp cv di ef em es fr hi ho id ih kl me pa pb pi px ra rp tb

OD If other diseases or significant abnormalities, **findings must be recorded on reverse.** (section 4C/4D)

Date Physician or Worker notified?

MONTH DAY YEAR

4E. Should worker see personal physician because of findings in section 4? YES NO

Proceed to Section 5

5. PHYSICIAN'S Social Security Number*

* Furnishing your social security number is voluntary. Your refusal to provide this number will not affect your right to participate in this program.

FILM READER'S INITIALS

DATE OF READING

MONTH DAY YEAR

LAST NAME - STREET ADDRESS

CITY STATE ZIP CODE

CDC/NIOSH (M) 2.8
REV. 7/2007

4C. MARK ALL BOXES THAT APPLY: (Use of this list is intended to reduce handwritten comments and is optional)

Abnormalities of the Diaphragm

- ☐ Eventration
- ☐ Hiatal hernia

Airway Disorders

- ☐ Bronchovascular markings, heavy or increased
- ☐ Hyperinflation

Bony Abnormalities

- ☐ Bony chest cage abnormality
- ☐ Fracture, healed (non-rib)
- ☐ Fracture, not healed (non-rib)
- ☐ Scoliosis
- ☐ Vertebral column abnormality

Lung Parenchymal Abnormalities

- ☐ Azygos lobe
- ☐ Density, lung
- ☐ Infiltrate
- ☐ Nodule, nodular lesion

Miscellaneous Abnormalities

- ☐ Foreign body
- ☐ Post-surgical changes/sternal wire
- ☐ Cyst

Vascular Disorders

- ☐ Aorta, anomaly of
- ☐ Vascular abnormality

4D. OTHER COMMENTS

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Public reporting burden of this collection of information is estimated to average 3 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control number. Send comments regarding this burden estimate or any other aspect of this collection information, including suggestings for reducing this burden to CDC, Project Clearance Officer, 1600 Clifton Road, MS E-11, Atlanta, GA 30333, ATTN: PRA (09020-0020). Do not send the completed form to this address.