AMCS
American Mining Claims Service
WEST VIRGINIA UNIT

Employee and Physician's Report of Occupational Hearing Loss

Return completed form to:
American Mining Claims Service
P.O. Box 660988
Birmingham, AL 35266-0988

PLEASE TYPE OR PRINT WITH A BLACK OR BLUE BALLPOINT PEN

SECTION I – TO BE COMPLETED BY CLAIMANT

1. Claimant's Name (First, Middle, Last)	2. Social Security Number
3. Mailing Address	4. Telephone Number

5. Date of Birth (Month, Day, Year)	6. Martial Status: ☐ Single ☐ Married ☐ Widowed	7. Gender: ☐ Female ☐ Male	8. County of Residence	9. Daily rate of pay on date last exposed to loud noise on job:

10. Check One: ☐ Still Working – Date last exposed to loud nose on job: / /

☐ Not Working – Date Last Worked: / / Reason no longer working:

11. Have you ever filed a hearing loss claim? ☐ Yes ☐ No Claim Number, if available:

12. Employment History: List all employment beginning with most recent (Attach a separate page if necessary).

Employer's Name and Address	From	To	Description of Duties

13. Explain **HOW** and **WHEN** your hearing loss was caused by industrial noise exposure

14. Date you were made aware you have suffered a noise induced hearing loss: / /

15. List **ALL** doctors you have seen for hearing loss or problems related to your ears. Attach a separate page is necessary.

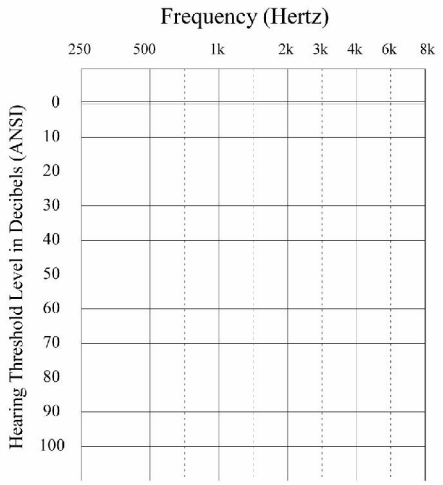
Name	Address	Date Seen

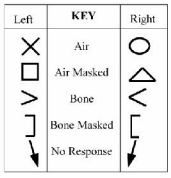
I certify the statements and answers set forth in this section are true and correct to the best of my knowledge and belief. I am aware the law, specifically WV Code § 61-3-24f, provides for severe penalties if I knowingly and with fraudulent intent withhold facts or make false statements in order to obtain or increase benefits to which I am not entitled. By signing this application, I authorize any physician to release to or orally discuss with, either my employer or an authorized agent of American Mining Claims Service, any medical records pertaining to the occupation injury or illness for which I am claiming benefits and any prior injury to or disease to the portion of my body for which I am alleging a medical impairment. I acknowledge the provisions of WV Code § 23-4-7 providing authorization for release of medical information by a physician to my employer or employer representative.

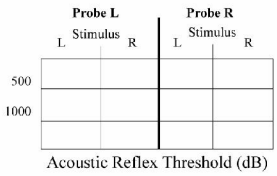
Claimant's Signature: **Date:**

SECTION II PART A – TO BE COMPLETED BY AUDIOLOGIST

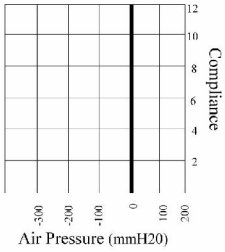
Only audiometric test results obtained by an audiologist having a certificate of clinical competence in audiology (CCC-A) or a West Virginia audiology licensure are acceptable for purpose of awarding compensation.







	Left	Right
SRT:		
Best 2f average (.5,1,2 kHz):		
Difference:		



Left	Right
____%@____dB	____%@____dB
____%@____dB	____%@____dB

Speech Discrimination (Word Recognition)
Materials used (e.g. W22):_____
25____ or 50 ____ word list, recorded____ or live voice____

1 kHz Ascending threshold Left _____ Right _____
1 kHz Descending threshold Left _____ Right _____

	500	1000	2000	3000	TOTAL	% Impairment MD
R air						
R bone						
L air						
L bone						

Test/Response Reliability: Good ☐ Fair ☐ Poor ☐

Audiologist Name (Print):_____ CCC/A or Licensed? Yes ☐ No ☐

Audiometer:_____
Electroacoustic Calibration ___/___/____ Listening Check ___/___/____ Audiologist Signature:_____ Date:_____

For AMCS Use Only	For Audiology Verification
BODY: A203 SOURCE: I-6 NATURE: G-2 TYPE: D-4	PTA/SRT within 10 db? ☐ Yes ☐ No Ascending / Descending thresholds within 5db? ☐ Yes ☐ No Reliability rated good? ☐ Yes ☐ No

SECTION II PART B – TO BE COMPLETED BY AN ENT, AN OTOLOGIST OR AN OTOLARYNGOLOGIST

If this information is not provided by an ENT, an Otologist, or an Otolaryngologist, American Mining Claims Service will not consider it in the compensability determination.

1. Chief complaints / symptoms as related to hearing loss

2. Employment History: List all employment beginning with most recent. Attach a separate page if necessary.

Employer's Name and Address	From	To	Description of Duties	Hearing Protection (Yes / No)

3. Diagnosis Code (ICD9-CM)	Medical History

4. List any pre-existing conditions that may have contributed to hearing loss

5. Examination Results

6. Does the claimant have a bilateral sensorineural hearing loss directly attributable to or perceptibly aggravated by industrial noise exposure in the course of and resulting from his/her employment? ☐ Yes ☐ No If yes, please answer A and B below.

A. Recommended percentage of impairment due to work-related noise exposure:

B. Explain and qualify:

7. Is further testing recommended? ☐ Yes ☐ No If yes, indicate type of testing.

8. Do you recommend additional treatment or correctional devices? ☐ Yes ☐ No If yes, explain.

9. Date you first informed the injured worker of the diagnosis of Noise-Induced Hearing Loss: / /

10. Physician's Name and Address:	11. Physician's Telephone Number
	12. Physician's FEIN

I certify the statements and answers set forth in this section are true and correct to the best of my knowledge. I am aware the law, specifically WV Code § 61-3-24g, provides for severe penalties if I knowingly certify a false report or statement, withhold material fact or statement or knowingly aid or abet anyone attempting to secure benefits to which he or she is not entitled. In signing this form, I acknowledge my contractual obligations to American Mining Claims Service and agree to release any office notes/test results immediately to American Mining Claims Service.

Physician's Signature **Date**

Please make copies of this form for the claimant, for your records and send the original to American Mining Claims Service

For more information, contact American Mining Claims Service at 1.888.823.4496