STATE OF WEST VIRGINIA
STATE AGENCY
WORKERS' COMPENSATION PROGRAM

Send Completed Form To:
Zurich Insurance
PO Box 66941
Chicago, IL 60666-0941
FAX: 847-240-8172

Physician's Report of Occupational Pneumoconiosis

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:
Accidents: ☐ 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, 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