Form OIC-WC-1OP

West Virginia Workers' Compensation
Employees' Report of Occupational Pneumoconiosis

PLEASE PRINT OR TYPE

Section I	Employee Information
Name:	**Telephone:**
Address:	**Social Security No.:**
City, State, Zip:	**Date of Birth:**
Gender: ☐ M ☐ F	**Marital Status:**
Date you were last exposed to minute particles of dust:	**Have you ceased work?** ☐ Y ☐ N **If yes, when?**
If you have ceased working, please explain why:	

Are you receiving Federal Black Lung or Workers' Compensation benefits for occupational pneumoconiosis from any state? ☐ Y ☐ N

If yes, please provide the following information:

- **What type of payments you are receiving:**
- **Date payments began (month/day/year):**
- **Monthly amount:**

List ALL workers' compensation claims for Occupational Pneumoconiosis (West Virginia and other states); Attach a separate sheet if necessary:

Claim No.:	Impairment %:	Date of Last Exposure:	Employer:	State:

List ALL disability claims you have filed with federal agencies (including Social Security, Veterans Administration, etc.):

Currently receiving?	Type of injury/medical condition:	Date began:	Monthly amount:
☐ Y ☐ N			
☐ Y ☐ N			

Do you have a family physician? ☐ Y ☐ N **If yes, please provide the following information:**

Physician's name:	Complete mailing address:	Telephone number:

Have you ever suffered any other accidents, injuries or illness(es) of the chest or lungs? ☐ Y ☐ N **If yes, provide the following information:**

Illness/Condition:	Date of onset:	Treating physician/Facility (Name, Address):	Were you hospitalized?	Did you require surgery?
			☐ Y ☐ N	☐ Y ☐ N
			☐ Y ☐ N	☐ Y ☐ N
			☐ Y ☐ N	☐ Y ☐ N

Do you have medical reports indicating that you have occupational pneumoconiosis? ☐ Y ☐ N **If yes, provide the following information:**

Date of diagnosis:	Physician name:	Complete Mailing Address:	Telephone No:	Diagnosed impairment %:

Have you had any of the following procedures performed within the last five (5) years? If yes, provide the following information:

Procedure:	Date of procedure:	Attending physician:	Hospital (name, address):
Chest X-Ray ☐ Y ☐ N			
Blood Gas Analysis ☐ Y ☐ N			
Breathing Studies ☐ Y ☐ N			
Tuberculosis Check ☐ Y ☐ N			

How long have you been exposed to the hazards of occupational pneumoconiosis while working in West Virginia?

List your employment history prior to your date of last exposure. Start with your most recent employer (or current employer if still employed). Union hall employment history printouts should be attached if applicable. Attach additional sheets if necessary:

Employer:	From:	To:	Location (Name of Site, City, State):	Type of Industry:	Job Title:	Alleged Exposure?
						☐ Y ☐ N
						☐ Y ☐ N
						☐ Y ☐ N
						☐ Y ☐ N
						☐ Y ☐ N
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						☐ Y ☐ N

I certify that the above is true and correct to the best of my knowledge. I am aware the law 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 hereby authorize any physician, chiropractor, surgeon, practitioner or other healthcare provider, any hospital, including Veterans' Administration or governmental hospital, and medical service organization, any insurance company, any law enforcement or military agency, any government benefit agency including the Social Security Administration, or any other institution or organization to release to each other, any medical, employment, wage or other information, including benefits paid or payable, pertinent to this injury or disease, except information relative to the diagnosis, treatment and/or counseling for HIV/AIDS, psychological conditions, and/or alcohol or substance abuse, for which I must give specific authorization. A Photostat of this authorization shall be as valid as the original.

Claimant's Signature: **Date:**

If you have an attorney, please provide:

Attorney Name:	Date Hired:	Attorney's Address	Attorney's Telephone No.:

Attorney's Signature: **Date:**