Form OIC-WC-1HL

West Virginia Workers' Compensation
Employees' and Physicians' Report of Occupational Hearing Loss

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:**

Check One: ☐ **Still Working – Date Last Exposed to Loud Noise on Job:**

☐ **Not Working – Date Last Worked:** **Reason No Longer Working:**

Have You Ever Filed a Hearing Loss Claim? ☐ **Y** ☐ **N**

- **If yes, provide Claim Number, Date of Last Exposure, Name of Employer and Name of Insurer, if applicable:**

EMPLOYMENT HISTORY: LIST ALL EMPLOYMENT, BEGINNING WITH THE MOST RECENT – USE SEPARATE SHEET IF NECESSARY

Employer Name and Address:	From:	To:	Description of Job Duties:

Explain HOW and WHEN your hearing loss was caused by exposure to noise at work:

Date on which you were made aware you have suffered noise-induced hearing loss:

Daily rate of pay on the last day you were exposed to noise at work: $

LIST ALL DOCTORS YOU HAVE SEEN FOR HEARING LOSS OR PROBLEMS RELATED TO YOUR EARS – USE SEPARATE SHEET IF NECESSARY

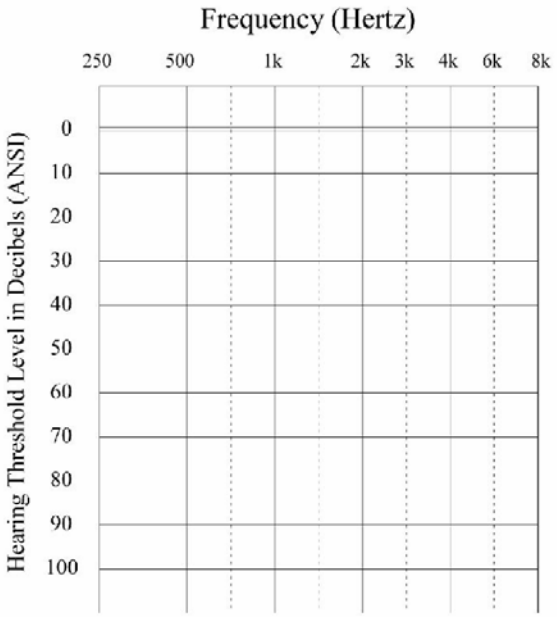
Name:	Address:	Date Seen:

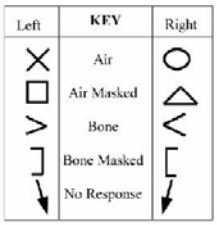
I certify that the above is true and correct to the best of my knowledge. I am aware the law provides for severe penalties if I knowingly and with fraudulent intent withhold facts or make false statements in order to obtain or increase benefits to which I am not entitled. By signing this application, 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 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.

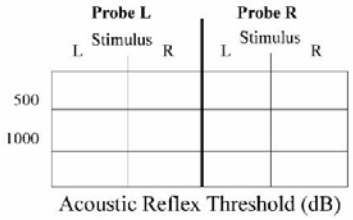
Signature: **Date:**

Section II – Part A — TO BE COMPLETED BY AUDIOLOGIST

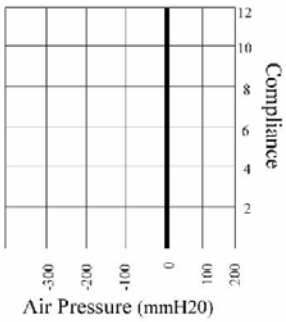
Only audiometric test results obtained by an audiologist having a certificate of clinical competence in audiology (CCCA) or a West Virginia audiology licensure are acceptable for purpose of awarding compensation.







	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:_____

PTA/SRT within 10 dB? ☐ Y ☐ N	Ascending/Descending thresholds with 5 dB? ☐ Y ☐ N	Reliability rated GOOD? ☐ Y ☐ N

Section II – Part B — MUST BE COMPLETED BY E.N.T., OTOLOGIST OR OTOLARYNGOLOGIST

EMPLOYMENT HISTORY: LIST ALL EMPLOYMENT, BEGINNING WITH THE MOST RECENT – USE SEPARATE SHEET IF NECESSARY

Employer:	From:	To:	Description of Duties/Nature of Noise Exposure:	Hearing Protection?
				☐ Y ☐ N
				☐ Y ☐ N
				☐ Y ☐ N
				☐ Y ☐ N

Chief complaints/symptoms as related to hearing loss:	ICD9-CM Diagnosis Code(s):

List any pre-existing conditions which may have attributed to hearing loss:

Section II – Part B (Continued) **MUST BE COMPLETED BY E.N.T., OTOLOGIST OR OTOLARYNGOLOGIST**

Examination Results:

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? ☐ **Y** ☐ **N** **If yes, please answer A and B below.**

A. Recommended percentage of impairment due to work-related noise exposure:	**B. Explain and qualify:**

Do you recommend additional treatment or correctional devices? ☐ **Y** ☐ **N** **If yes, explain:**

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

Physician's Name and Address:	**Telephone Number:**	**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 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 I have been informed of my responsibilities under West Virginia's Workers' Compensation Law and agree to abide by such in the administration of services provided thereunder. I understand the submission of false statements or billing may result in prosecution under state and federal law. I further agree to release any office notes/test results immediately to the employer or their representative.

Signature: **Date:**