OCCUPATIONAL DISEASE OR ILLNESS REPORT

PLEASE PRINT IN INK **To be completed by Employee**

Employer:

Name________________________ Social Sec. No.________________________

Home Address________________________ Birth date____________ Sex: ☐ Male ☐ Female

City/State/Zip________________________ Telephone: ( )________________________

Occupation________________________ Department________________________

Date of injury or onset of symptoms________________________ Time____________ ☐ am ☐ pm

Type of job performed when symptoms first appeared________________________

Number of months/years in above job________________________

Number of months/years total with this employer________________________

Name of your previous employer________________________

Did you report or mention your symptoms to anyone? ☐ Yes ☐ No If yes, to whom?________________________

What was the length of time between the onset of your symptoms and your disability, if any?________________________

Will the condition require further treatment or prevent you from working? ☐ Yes ☐ No If yes, please explain:________________________

____

____

Date of diagnosis or first treatment for this condition________________________ Current diagnosis________________________

Doctor's name, address and phone: ________________________

____

____

____

Have you ever experienced this condition before? ☐ Yes ☐ No If yes, please explain in full detail:________________________

____

Medical visits during the last five years: ________________________

____

____

Current medications prescribed by your doctor(s); include doctor's name:________________________

____

____

Medical Release

Under current workers' compensation provisions, the employer is entitled to a signed medical release

I hereby authorize any person or persons who have in the past or will in the future medically attend, treat or examine me, or any person who may have information of any kind which may be used to reach a decision in any claim for injury or disease arising from the injury/illness described above, to **disclose such information** to my employer, my employer's managed care organization, or to my employer's designated representative, **CompManagement, Inc.** A copy of this form will serve as the original.

Employee Name (print)________________________

Employee Signature________________________ Date (required)________________________