Department of Labor and Industries
PO Box 44291
Olympia WA 98504-4291

OCCUPATIONAL DISEASE & EMPLOYMENT HISTORY

Name	Claim Number

Occupational Disease Information Form

This form must be completed if the claim isn't the result of a specific incident.
An occupational disease is a condition caused by job duties or work conditions over a period of time.

RESET

For allowance of an occupational disease claim, there must be:

- Medical evidence supported by objective medical findings that the disease exists.
- Medical opinion that the diagnosis is caused by work activities on a more probable than not basis.
- Documentation that the disease was caused by work rather than conditions in everyday life or all employment in general.

We require completion of this form to decide if the claim is allowable and to determine which job(s) contributed to the diagnosed condition.

Instructions for Worker

- Complete the **Worker Information** and the **Employment History**.
- Include all current and past employer(s).
- Provide as much detail as possible about your employer(s) and your job duties.
- Inaccurate or incomplete information may delay our decision.
- Failure to complete and submit this form may result in claim rejection.

Worker Information

What symptoms are you having? _____
_____
_____
_____
_____
_____

When did you first notice these symptoms? ____/____/____

What were you doing when these symptoms began?
_____
_____
_____

Has there been any recent change in your work duties that have affected your symptoms? ☐ YES ☐ NO

If yes, please describe: _____
_____

Have you ever been seen by a provider for these symptoms in the past?
☐ YES ☐ NO

If yes: Provider's name:_____
Date/Year Seen:_____
Provider's Address/City/State:_____
_____

If yes, complete the attached medical records release form.

Have you previously filed any claims for this condition?
☐ YES ☐ NO If yes, please list the states and claim numbers:

State:	Claim Number:

Other Activities – *Complete the following for activities that you currently do or have done in the past.*

☐ Sports – type _____ hrs per day: ____
days per wk: ____
Performed From: _____/_____/_____ To: _____/_____/_____

☐ Sewing, Knitting, Crocheting, Crafts, etc. hrs per day:____
days per wk: ____
Performed From: _____/_____/_____ To: _____/_____/_____

☐ Woodworking/Construction/Painting/Gardening hrs per day: ____
days per wk: ____
Performed From: _____/_____/_____ To: _____/_____/_____

☐ Computers, Keyboarding, Gaming, Text Messaging, etc. hrs per day: ____
days per wk:____
Performed From: _____/_____/_____ To: _____/_____/_____

☐ Musical Instruments – type _____ hrs per day: ____
days per wk: ____
Performed From: _____/_____/_____ To: _____/_____/_____

☐ Auto/Engine Repair, Firearms, Power Tools, etc. hrs per day: ____
days per wk:____
Performed From: _____/_____/_____ To: _____/_____/_____

☐ Other – describe:_____ hrs per day: ____
Performed From: _____/_____/_____ To: _____/_____/_____ days per wk: ____

RESET

Name ____________ Claim Number ____________

Employment History – *Include **all** employers. Copy this page if you need more space.*		For LNI use
Current or Last Employer: ____________ Job Title: ____________ Dates Employed: From ___/___/___ To ___/___/___ Phone Number: ____________ Address: ____________ City/State: ____________ Was there a gap of more than two months between this job and your prior job? Yes ☐ No ☐ If yes, please briefly explain: ____________	Check the specific job condition(s) you believe caused your symptoms: Job Duties — Hrs per day — Days per week ☐ Pushing/Pulling ____ ____ ☐ Use of Vibratory Tools ____ ____ ☐ Kneeling ____ ____ ☐ Overhead Work ____ ____ ☐ Pinching ____ ____ ☐ Keyboarding ____ ____ ☐ Lifting/Carrying ____ ____ ☐ Other Repetitive Tasks: ____ ____	
Prior Employer: ____________ Job Title: ____________ Dates Employed: From ___/___/___ To ___/___/___ Phone Number: ____________ Address: ____________ City/State: ____________ Was there a gap of more than two months between this job and your prior job? Yes ☐ No ☐ If yes, please briefly explain: ____________	Check the specific job condition(s) you believe caused your symptoms: Job Duties — Hrs per day — Days per week ☐ Pushing/Pulling ____ ____ ☐ Use of Vibratory Tools ____ ____ ☐ Kneeling ____ ____ ☐ Overhead Work ____ ____ ☐ Pinching ____ ____ ☐ Keyboarding ____ ____ ☐ Lifting/Carrying ____ ____ ☐ Other Repetitive Tasks: ____ ____	
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Worker Statement: I declare that the information I've provided on this form is true to the best of my knowledge and understanding.

Worker's Signature: ____________________ Date: ____________