



NOTICE OF OCCUPATIONAL DISEASE OR INFECTION

Medical Provider: If you examined this worker and diagnosed him/her with an occupational disease or infection:

1.) Inform the worker of their right to file an occupational disease claim. If the worker requests, complete a Report of Industrial Insurance or Occupational Disease form and follow its mailing instructions.

If a Report of Industrial Insurance or Occupational Disease form is not completed by you and the worker:

- 1.) Inform the worker that he or she must file a claim within two years from the date this form is signed and a copy is provided to him or her.
- 2.) Complete and sign this form.
- 3.) Provide a **copy** of this form to the worker.
- 4.) Mail the **original** of this form to the address above.

Note to medical provider: Please have the worker help you complete this section of the form

Worker's name		Phone number	Social Security number (ID only)	
Date of birth	Sex	Worker's occupation		
Current home address		City	State	ZIP
Mailing address if different		City	State	ZIP
Business name of employer where most recent injurious exposure or activity occurred			Phone number	
Employer's address		City	State	ZIP
Length of employment with this employer?	From: (mm/yy)	To: (mm/yy)	Date of last injurious exposure or activity	
Name of previous employers			From: (mm/yy)	To: (mm/yy)

Describe the exposure or activity which appears to have caused the occupational disease or infection _____

Medical Provider: Please complete the section below in full

Medical provider's name		Phone number		
Address		City	State	ZIP
Provisional diagnosis (Use both standard description and ICD code)		Date of first treatment (mm/yy)	Provider account/NPI number	
Type of exposure which caused the occupational disease/injury (Such as noise, specific chemicals, toxic substances, specific job-related activities, bacterial or viral infections) _____				

I certify that I have examined this worker and have determined that he or she has a disease or infection (diagnosed above) caused by his or her occupation. I have advised the worker of his/ her right to file a claim for workers' compensation benefits. I also explained that claims must be filed within two years from the date this form is signed and provided to the worker.

Licensed physician must sign	Today's date (mm/dd/yy)	Signature
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