STATE OF WEST VIRGINIA
STATE AGENCY
WORKERS' COMPENSATION PROGRAM

Send Completed Form To:
Zurich Insurance
PO Box 66941
Chicago, IL 60666-0941
FAX: 847-240-8172

Employee and Physician's Report of Occupational Hearing Loss

SECTION 1 – TO BE COMPLETED BY CLAIMANT

1. Claimant's Name(First, Middle, Last):	2. Social Security Number:
3. Mailing Address:	4. Telephone Number:

5. Date of Birth:	6. Marital Status: ☐ Single ☐ Married ☐ Widowed	7. Gender: ☐ Male ☐ Female	8. County of Residence:	9. Daily rate of pay on date last exposed to loud noise on job: $

10. Check one: ☐ Still Working – date last exposed to loud noise on job was _____

☐ Not Working – date last worked was _____ Reason no longer working:

11. Have you ever filed a hearing loss claim? ☐ Yes ☐ No Claim Number if available:

12. Employment History: List all employment beginning with most recent (Attach a separate page if necessary).

Employer's Name and Address	From	To	Description of Duties

13. Explain **HOW** and **WHEN** your hearing loss was caused by industrial noise exposure:

14. Date you were made aware you have suffered a noise induced hearing loss**:** _____

15. List **ALL** doctors you have seen for hearing loss or problems related to your ears. (Attach a separate page if necessary).

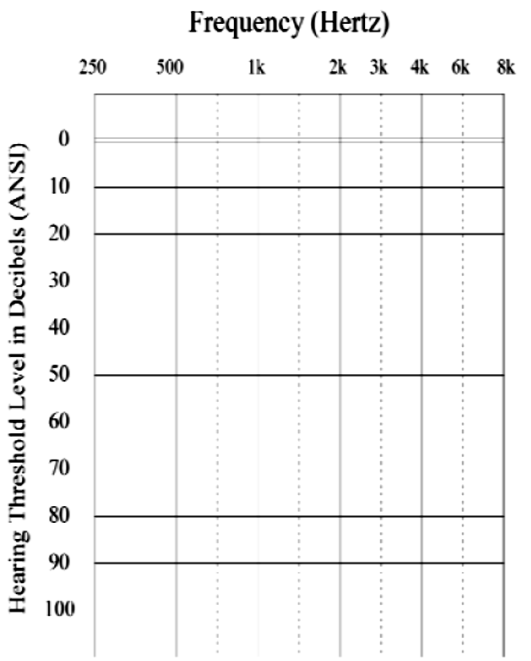
Name	Address	Date Seen

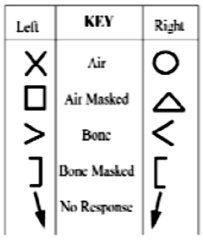
I certify the statements and answers set forth in this section are true and correct to the best of my knowledge and belief. I am aware the law, specifically WV Code §61-3-24f, provides severe penalties if I knowingly and with fraudulent intent withhold facts or make false statements in order to obtain or increase benefits to which I am not entitled. By signing this application, I authorize any physician to release to or orally discuss with, either my employer or an authorized agen of Zurich Insurance, any medical records pertaining to the occupational injury or illness for which I am claiming benefits an any prior injury to or dissease to the portion of my body for which I am alleging a medical impairment. I acknowledge the provisions of WV Code §23-4-7 providing authorization for release of medical information by a physician to my employer or employer representative.

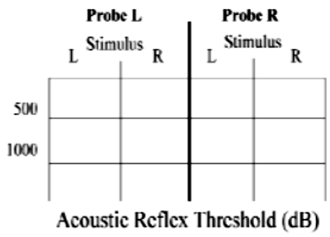
Claimant's Signature: **Date:**

SECTION II PART A – TO BE COMPLETED BY AUDIOLOGIST

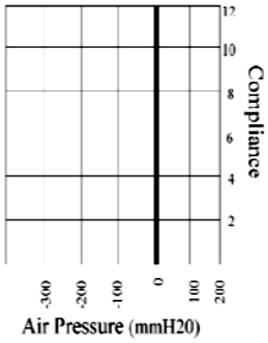
Only audiometric test results obtained by an audiologist having a certificate of clinical competence in audiology (CCC-A) or a West Virginia audiology licensure are acceptable for purpose of awarding compensation.







	Left	Right
SRT:		
Best 2f average (.5,1,2 kHz):		
Difference:		



Left		Right	
%@	dB	%@	dB
%@	dB	%@	dB

1 kHz Ascending threshold Left _____ Right _____

1 kHz Descending threshold Left _____ Right _____

Speech Discrimination (Word Recognition)
Materials used (e.g. W22):
25____ or 50 ____ word list, recorded____ or live voice____

	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:_____

SECTION II PART B – TO BE COMPLETED BY AN ENT, AN OTOLOGIST OR AN OTOLARYNGOLOGIST

If this information is not provided by an ENT, an Otologist or an Otolaryngologist, Zurich Insurance will not consider it in the compensability determination.

1. Chief complaints / symptoms as related to hearing loss:

2. Employment History: List all employment beginning with most recent. Attach a separate page if necessary.

Employer's Name and Address	From	To	Description of Duties	Hearing Protection (Y/N)

3. Diagnosis Code (ICD10-CM):

Medical history:

4. List any pre-existing conditions that may have contributed to hearing loss:

5. Examination Results:

6. Does the claimant have bilateral sensorineural hearing loss directly attributable to or perceptibly aggravated by industrial noise exposure in the course of and resulting from his/her employement? ☐ Yes ☐ No If Yes, please answer A. and B. below.

A. Recommended percentage of impairment due to work-related noise exposure: _____

B. Explain and qualify: _____

SECTION II PART B – CONT

7. Is further testing recommended? ☐ Yes ☐ No If yes, indicate type of testing.

8. Do you recommend additional treatment or corrective devices? ☐ Yes ☐ No If yes, explain.

9. Date you first informed the injured worker of the diagnois of noise-induced hearing loss? _____

10. Physician's Name and Address:	11. Physician's Telephone Number:
	12. Physician's 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, specifically WV Code § 61-3-24g, 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 my contractual obligations to Zurich Insurance and agree to release any office notes/test results immediately to Zurich Insurance.

Physician's Signature: **Date:**