OCCUPATIONAL DISEASE OR ILLNESS REPORT

PLEASE PRINT IN INK **To be completed by Employee and sent to workplaceinjury@cscc.edu**

Employer:

Name________________________________ Employee CID ________________________

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)____________________