DR. MORLEY SLUTSKY
WORK RELATED HEARING LOSS EVALUATIONS
SCHEDULING: (800) 990-7924 FAX: (888) 418-7997
WWW.HEAREXAMS.COM

Dear Patient:

Here are a few things to check prior to coming to the appointment with Dr. Slutsky:

ALL FORMS/MAPS CAN BE FOUND ON MY WEBSITE: **WWW.HEAREXAMS.COM**

1. **VERIFY WORKER'S COMPENSATION INSURANCE:**
Workers Compensation Insurance will **either be processed through L&I's STATE FUND OR through the SELF-INSURED EMPLOYER (self-insured claims need you to obtain an SIF-2 FORM PRIOR TO being evaluated, see below).**
It is the **MOST RECENT WA STATE EMPLOYER** where you **WORKED IN LOUD NOISE EVEN FOR ONE DAY** (**THAT PAID WA L & I INSURANCE FOR YOU**) that determines if the claim is **STATE FUND** OR **SELF INSURED**.

☐ Look for the **EMPLOYERS NAME** AT L&I'S **SELF INSURED EMPLOYER WEBSITE http://www.lni.wa.gov/ClaimsIns/Insurance/SelfInsure/EmpList/FindEmps/Default.asp**.

☐ It is the **LAST DAY OF EMPLOYMENT AT THE COMPANY** that determines if the claim falls within the **COMPANIES SELF-INSURED PERIOD.**

*1. EXAMPLE: IF L&I'S WEBSITE SAYS THAT THE ACME COMPANY WAS SELF INSURED FROM **1/21/2000** TO **3/21/2008**, AND IF THE PATIENT 's LAST DATE OF EMPLOYMENT WAS **3/24/2008**, then the claim is **STATE FUND**.*

*2, ALTERNATIVELY IF THE PATIENT LAST WORKED FOR THE COMPANY ON **5/4/2006**, THE CLAIM IS **SELF-INSURED** AND **PATIENT NEEDS THE SIF-2 FORM** PRIOR TO COMING TO SEE DR. SLUTSKY (**PLEASE SEE BELOW**).*

☐ **SELF INSURED CLAIMS**: If your **employer is self-insured** on your last day of employment or if you currently work at a self-insured company, then you **MUST** obtain a **Self-Insurance Form-2** (**SIF-2-form**) **prior to your medical appointment.**

☐ The **SIF-2** may be obtained from the **Self-Insured Employer** (their Workers Comp /H.R. / Benefits Department) or you may call the **Third Party Administrator, TPA for this Employer** (look at L & I's Self Insured Employer Website, above, for this). **BRING A COPY OF THE SIF-2 FORM INTO YOUR MEDICAL APPOINTMENT.**

2. **EMPLOYMENT HISTORY HEARING LOSS FORMS**

☐ **Make a COPIES OF THESE FORMS FIRST PRIOR TO COMPLETING SO THAT YOU ALWAYS HAVE BLANK COPIES.**

☐ STRONGLY RECOMMEND YOU ORDER YOUR **FREE WA STATE WORK HISTORY** FROM WA EMPLOYMENT SECURITY DEPT. AND B**RING THIS TO YOUR APPOINTMENT WITH DR. SLUTSKY**. See attached forms with instructions.
This WA STATE employment history goes back to 1987 and is a starting point for you. PLACE ALL EMPLOYERS (regardless of they are WA sate employers, in another State, Federal employers, etc.). **ON THE EMPLOYMENT HISTORY HEARING LOSS FORMS.**

☐ **Must complete Employment History going BACK TO when you FIRST WORKED EVER. Must place Start and End Dates (WITH MONTHS and YEARS) of EMPLOYMENT.**
Start with most recent employer and work backwards to the first employer.

☐ L & I ALLOWS GUESSING AT EMPLOYMENT IF YOU ARE ARE UNSURE OF EMPLOYMENT DATES. IF YOU CANNOT REMEMBER ALL EMPLOYMENT, I CAN ASK L & I TO ORDER YOUR **SOCIAL SECURITY REPORT** HOWEVER THIS **MAY DELAY YOUR CLAIM'S PROCESSING**.

3 OCCUPATIONAL HEARING LOSS QUESTIONNAIRE:

☐ **Review the Occupational Hearing Loss Questionnaire** (2 pages) to make sure they are complete. You may leave areas blank if you are unsure what to fill in and can discuss this with Dr. Slutsky.

☐ **Please make sure to place all medication names in block 10 on this form or bring a list of medications with you.**

4 PRIOR HEARING TESTS

☐ **ALL prior hearing tests** must be **accounted for** (with the exception of testing in grade school and military testing).

A. Please obtain copies of the tests and bring to the appointment

B. If you had **employment related hearing tests then contact the employer and or vendor who performed the tests and ask for a copy**.

C. If the establishment no longer exists and there is no one to contact then discuss with Dr. Slutsky.

5. PRIOR MEDICAL EVALUATIONS FOR HEARING LOSS BY A PHYSICIAN

☐ ALL **prior medical evaluations** for hearing loss with a Medical Doctor (M.D. or D.O.) must be accounted for. If the establishment no longer exists and there is no one to contact for this information then discuss this with Dr. Slutsky.

☐ **POTENTIAL OUTCOMES FOR PRIOR HEARING TESTS AND MEDICAL INFORMATION**

A. The place where you had the hearing test gives you a copy of the evaluation (which you should bring with you to the appointment) or they may fax this test to Dr. Slutsky's office at (888) 699-0003.

B. If it is a work related hearing test then please contact the employer or their vendor (who performed the testing) and ask for a copy.

C, Employers (and their vendors) are required to keep tests for a long time so they may still have copies.

D. If you are told the test and or medical evaluations no longer exit then please document the **name and phone number of the person who said the test is no longer available** and bring this information to the appointment.

E If the establishment where testing / medical evaluations no longer exists and there is no one to contact then discuss with Dr. Slutsky.

6. **NO SIGNFICANT NOISE EXPOSURE AT LEAST 14 HOURS PRIOR TO THE APPOINTMENT**

The Washington State Department of Labor and Industries does not allow individuals to be tested unless they have had **minimal exposure to loud noise for at least 14 hours prior to the visit.**

This means for example no riding motorcycles, shooting guns, or working in loud noise for at least 14 hours before being seen.

6. **CANCELLING / MISSING YOUR APPOINTMENT**

Please notify our Office **AT LEAST 24 hours in advance at (800) 990-7924** if you are going to miss an appointment and need to reschedule.

DR. MORLEY SLUTSKY
GENERAL OFFICE POLICIES
WWW.HEAREXAMS.COM
Office: 800 990 7924
Fax: 888 418 7997
Mailing Address: 4580 Klahanie Dr. SE, #125 Sammamish WA 98029

GENERAL OFFICE POLICIES

Dear Patients, Please be aware of Dr. Slutsky's Policies (below)

DUE TO POTENTIAL SPREAD OF CORONA VIRUS, WE ASK ONLY THE PATIENT ATTEND THE APPOINTMENT AND THAT IF SOMEONE COMES WITH THE PATIENT, THEY WAIT IN THEIR VEHICLE OR COME BACK TO PICK THE PATIENT UP IN THE PARKING AREA. THERE WILL BE ONLY ONE CHAIR IN WAITING AREAS.

PLEASE BRING A MASK / FACE COVERING TO YOUR APPOINTMENT.

1. No Guns are allowed in Dr. Slutsky's office.

2. No Animals are allowed in Dr. Slutsky's office. The only exception is a **Certified Service Animal** however you must arrange this visit in advance with Dr. Slutsky's staff.

3. Small Children, **Babies who are not able to sit quietly** may not be brought into my office for the appointment as we will not be able to perform a valid Hearing Test.

4. Patients must have **14 hours of Low or No Noise Exposure prior to their appointment**. Otherwise a valid Hearing test cannot be performed

INDIVIDUALS WITH FLU LIKE SYMPTOMS / CORONA VIRUS LIKE SYMPTOMS, / BEEN EXPOSED TO SOMEONE WHO HAS THE CORONA VIRUS / HAVE LABORATORY CONFIRMED POSITIVE CORONA VIRUS

If you have the Flu-Like, Corona Virus-Like Symptoms and have not tested positive for The Corona Virus: Fever (over 99 degrees F / over 37 C), Cough, New Shortness of Breath / Difficulty Breathing, Chills, Repeated Shaking with Chills, New Muscle Pain, New Headache, Sore Throat, New Loss of Taste or Smell

AND / OR have been in Contact with someone who has Laboratory Confirmed Corona Virus

AND / OR If you have Laboratory Confirmed Corona Virus

AND You have an Appointment with Dr. Slutsky (**Next Page**)

DR. MORLEY SLUTSKY
GENERAL OFFICE POLICIES
WWW.HEAREXAMS.COM
Office: 800 990 7924
Fax: 888 418 7997
Mailing Address: 4580 Klahanie Dr. SE, #125 Sammamish WA 98029

Please make sure you do the following:

INDIVIDUALS WITH FLU LIKE SYMPTOMS / CORONA VIRUS LIKE SYMPTOMS, / BEEN EXPOSED TO SOMEONE WHO HAS THE CORONA VIRUS / HAVE LABORATORY CONFIRMED POSITIVE CORONA VIRUS

1. Call Dr. Slutsky's office and **Cancel your appointment ASAP**.

2. **Do not attend the Appointment** as you may be responsible for infecting other patients and or Dr. Slutsky.

3. You may call to Reschedule an Appointment under the following circumstances:

A. You have had **no fever for at 3 days / 72 hours without the use medicine that reduces fevers**.

AND

B. Other **Symptoms** (mentioned above) have **resolved** (for example, when your cough or shortness of breath have resolved).

AND

C. **at least 10 days have passed since your symptoms first appeared.**

MORLEY SLUTSKY M.D., M.P.H., F.A.C.O.E.M.

PATIENTS PLEASE COMPLETE THIS INTAKE FORM

PATIENT NAME:_____

DOB: _____**SOCIAL SECURITY #**_____

1. Below, please list **ALL** Medical Doctors (M.D., D.O.) who have evaluated you for Hearing Loss / performed Hearing Test(s) and obtain **ALL** copies of Medical Reports and Hearings Test from these Providers:_____

_____

If the Medical and or Hearing Tests are no longer available, please document the name and phone number of person(s) who told you that this information is no longer available.

2. History of Medical Treatment for Dizziness or Vertigo: **YES** ☐ **NO** ☐

IF YES: Discuss how long ago this was, if your received medications and if this condition was associated with permanent hearing loss.

_____

3. Below, please list **ALL** surgeries throughout your **Entire Life** (where you were put to sleep during the procedure). We do not need the dates, but we do need to know what body areas (including right and left sides) affected

_____

_____

4. EVER SMOKED CIGARETTES (Does not matter if you quit):

YES ☐ **NO** ☐: # Years Smoked: _____ Packs Per Day: _____

5: MILITARY SERVICE (does not matter which County's' Military you Served In): **YES** ☐ **NO** ☐

Branch of Military: _____ Start: (Mo/Year): _____ End (Mo/Year) _____

List Loud Noise Exposures in the Military:_____

_____

Did you notice Hearing Loss While IN or When YOU LEFT the Military: **YES** ☐ **NO**☐

Did the Military Perform a Hearing Test: **YES** ☐ **NO**☐

PROVIDED BY THE OFFICE OF DR. M. SLUTSKY

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

Employment History – Hearing Loss

Name	Claim Number
	Start Date of First Employment

Breaks in Employment History

Please list any break or interruption in your work history. *We must account for all months since your **first start date.***

From (Month/Year)	To (Month/Year)	Reason for Work Interruption

Employment History

Begin with your current job and list all prior employers. Include military service. Specify month and year for employment dates.

Employer Name	Phone Number		
Employer Address	City	State	Zip Code

Job Title	From (Month/Year)	To (Month/Year)	Indicate Time Exposed to Noise in **Hours per Week**
Describe job duties; type of machinery, tools, materials, and equipment used; and percentage of time at duties:			

Were you exposed to loud noise on this job? ☐ Yes ☐ No

If yes, describe the noise source: _____

Would you describe the noise as: ☐ Continuous ☐ Intermittent

How many hours a day were you exposed to this job noise? _____ hours

What kind of ear protection did you use?

☐ None ☐ Ear Muffs ☐ Plastic Ear Plugs ☐ Foam Ear Plugs ☐ Other:_____

Did you have an audiogram while working for this employer? ☐ Yes ☐ No

If yes, date(s) of audiogram(s):_____

I certify that the information is true and correct to the best of my knowledge.

Signature _____ Date _____

PROVIDED BY THE OFFICE OF DR. M. SLUTSKY

If additional sheets are needed, copy this page. ***Begin with current job and list all prior employers including military service.***

	Claim Number
Name	Start Date of First Employment

Employer Name	Phone Number		
Employer Address	City	State	Zip Code

Job Title	From (Month/Year)	To (Month/Year)	Indicate Time Exposed to Noise in **Hours per Week**
Describe job duties; type of machinery, tools, materials, and equipment used; and percentage of time at duties:			

Were you exposed to loud noise on this job? ☐ Yes ☐ No

If yes, describe the noise source: _____

Would you describe the noise as: ☐ Continuous ☐ Intermittent

How many hours a day were you exposed to this job noise? _____ hours

What kind of ear protection did you use?

☐ None ☐ Ear Muffs ☐ Plastic Ear Plugs ☐ Foam Ear Plugs ☐ Other:_____

Did you have an audiogram while working for this employer? ☐ Yes ☐ No

If yes, date(s) of audiogram(s):_____

Employer Name	Phone Number		
Employer Address	City	State	Zip Code

Job Title	From (Month/Year)	To (Month/Year)	Indicate Time Exposed to Noise in **Hours per Week**
Describe job duties; type of machinery, tools, materials, and equipment used; and percentage of time at duties:			

Were you exposed to loud noise on this job? ☐ Yes ☐ No

If yes, describe the noise source: _____

Would you describe the noise as: ☐ Continuous ☐ Intermittent

How many hours a day were you exposed to this job noise? _____ hours

What kind of ear protection did you use?

☐ None ☐ Ear Muffs ☐ Plastic Ear Plugs ☐ Foam Ear Plugs ☐ Other:_____

Did you have an audiogram while working for this employer? ☐ Yes ☐ No

If yes, date(s) of audiogram(s):_____

I certify that the information is true and correct to the best of my knowledge.

Signature _____ Date _____

PROVIDED BY THE OFFICE OF DR. M. SLUTSKY

Mail completed forms to:
Department of Labor and Industries
PO Box 44291
Olympia WA 98504-4291

Occupational Hearing Loss Questionnaire

Name	Claim Number	Injury Date

1. When did you first notice your hearing loss?

2. Was the onset of the hearing loss:
☐ Sudden ☐ Gradual

3. What kind(s) of hearing problems are you having? (Circle letter of all applicable items.)

A. Ringing in ears.
B. Difficulty hearing on the phone.
C. Difficulty hearing spoken communication in one-on-one conversation.
D. Difficulty understanding spoken communication in the presence of surrounding noise.
E. Other – explain:

4. While employed, did your hearing loss interfere with your work?

☐ No
☐ Yes – explain below:

5. Name and address of doctor who told you your hearing loss was occupational?

Name

Address

City State Zip Code

6. How were you notified?

☐ Written (please attach a copy)
☐ Oral
☐ Other – explain below:

7. Have you been examined by any other doctor in the past for hearing loss:

☐ No
☐ Yes – please provide:

Doctor's Name

Address

City State Zip Code

Exam Date Audiogram Done? ☐ No ☐ Yes

Doctor's Name

Address

City State Zip Code

Exam Date Audiogram Done? ☐ No ☐ Yes

8. When you were first told by a doctor that your hearing loss was caused by work noise, did he/she also tell you that you should have:

A. Medical Treatment – ☐ No ☐ Yes – explain below:

B. A hearing aid – ☐ No ☐ Yes

C. Did you have an audiogram? ☐ No ☐ Yes

9. Have you ever had hearing aids in the past?

☐ No
☐ Yes – please provide:

Doctor's Name/Clinic Name

Address

City State Zip Code

10. Do you have a health problem for which you must take medication on a regular basis?
☐ No ☐ Yes – explain the health problem and what kind of medication you are taking below:

11. Name and address of doctor prescribing your medications:

Doctor's Name

Address

City State Zip Code

12. Have you had any injury to your ear(s)?

☐ No
☐ Yes – explain below:

13. Have you had any illness that affected your ears or hearing?
☐ No
☐ Yes – indicate when and name of illness:

14 Have you ever had a head injury?
☐ No
☐ Yes – describe the injury below:

15. Have you had any illness involving high fever?
☐ No
☐ Yes – indicate when and name of illness:

16. Have any members of your family suffered hearing loss?
☐ No
☐ Yes – specify relationship (mother, father, uncle, etc):

17. Were you a member of a union or trade when exposed to the noise that you think contributed to your hearing loss?
☐ No
☐ Yes – which union?

18. Do you have any hobbies of non-work activities which involved loud noise such as: (check all that apply)

☐ Loud Music	☐ Snowmobiling	☐ Flying Aircraft
☐ Auto Repair	☐ Motorbiking	☐ Operating Noisy Equipment such as:
☐ Woodworking	☐ Boating	☐ Tractors
☐ Metal Working	☐ Hunting/Target Practicing	☐ Farm Equipment
☐ Wood Cutting	☐ Auto Racing	☐ Lawn Mowers
		☐ Other – please specify:

19. Type of equipment or tools used for hobbies: How Often? How Long (time/duration)?

Please list any hobbies or activities you participate in that involve noise?

20. Current or last rate of pay:
Amount:
$
Rate of pay:
☐ Hour ☐ Day ☐ Week ☐ Month

21. Are you retired?
☐ No
☐ Yes

21A. If you're retired, why did you retire?

21B. If you're retired, what is the last date you worked when you were exposed to noise that you think contributed to your hearing loss? (Give the month and year.)

21C. Did you have a hearing test as any part of a physical exam when you retired?
☐ No
☐ Yes

22. Was your employer contributing to your and/or your family's medical dental, and/or vision insurance on the last day you worked when exposed to noise that you think contributed to your hearing loss?
☐ No
☐ Yes

Date _____ Signature _____

PROVIDED BY THE OFFICE OF DR. M. SLUTSKY

(Select one) Language Preference ☐ English ☐ Spanish ☐ Russian ☐ Korean ☐ Chinese ☐ Vietnamese ☐ Laotian ☐ Cambodian ☐ Other _____

MAIL TO SELF-INSURED COMPANY

PROVIDER'S INITIAL REPORT

A Provider's Initial Report (PIR) completed by the provider and the worker, establishes a claim. When the completed PIR is received by the employer, they must assign a claim number and adjudicate the claim.

1.CLAIM NUMBER

1. NAME OF SELF-INSURED EMPLOYER

ADDRESS

CITY | STATE | ZIP

2. NAME OF SELF-INSURED EMPLOYER'S SERVICE REPRESENTATIVE

ADDRESS

CITY | STATE | ZIP

EMPLOYER'S TELEPHONE NUMBER | EMPLOYER'S SERVICE REP PHONE

PATIENT INFORMATION

2. NAME OF INJURED WORKER: FIRST MIDDLE LAST | 3. WORKER'S TELEPHONE NO.

4. MAILING ADDRESS | 5. SOCIAL SECURITY NUMBER

6. CITY | STATE | ZIP | 7. DATE OF BIRTH

8. INJURY DATE | 9. TIME | ☐ AM ☐ PM | 10. Have you missed work due to your injury? If so, what dates were you off? From: | To:

11. SEX | 12A. MARITAL/REGISTERED DOMESTIC PARTNERSHIP STATUS | 12B. NUMBER OF DEPENDENTS

13. Describe in detail how your injury or exposure occurred:

Attending Health Care Provider – **START HERE**

3. This exam date

4. Date patient first seen by you for this injury/condition

a. ICD Dx CODES	b. Diagnosis – specify Right/Left

5. Are there objective findings to support this diagnosis
☐ No ☐ Yes, Specify

6. Referred for Diagnostic Studies
☐ No ☐ Yes, Specify

7. Treatment Recommendations

8. Did you refer the patient to an L&I medical network provider for follow-up?
☐ YES ☐ NO Referred to:

Address

Phone

14. MEDICAL RELEASE AUTHORIZATION: PURSUANT TO RCW 51.36.060, I HEREBY AUTHORIZE MY HEALTH CARE PROVIDER, HOSPITAL, AGENCY OR ORGANIZATION TO DISCLOSE TO MY EMPLOYER OR MY EMPLOYER'S REPRESENTATIVE OR THE DEPARTMENT OF LABOR & INDUSTRIES ANY RELEVANT MEDICAL RECORDS OR OTHER INFORMATION REGARDING TREATMENT WHICH HAS PREVIOUSLY BEEN FURNISHED TO ME.

Worker's Signature Date

15. I have read the statement of Responsibility and the Legal Notice on the next page of this form.

Worker's Signature Date

9. a. Has the worker ever been treated for the same or similar condition? Select one. If YES, describe briefly or attach report.
No ☐ Yes ☐

b. Is there any pre-existing impairment of the injured area? Select one. If YES, describe briefly or attach report.
No ☐ Yes ☐

c. Are there any conditions that will prevent or retard recovery? Select one. If YES, describe briefly or attach report.
No ☐ Yes ☐

d. Was the diagnosed condition caused by this work injury or exposure on a more probable than not basis? (check one)
Yes ☐ Probably (51% or more) ☐
No ☐ Possibly (Less than 50%) ☐

10. a. Have you released this worker to return to regular work?
No ☐ Yes ☐ effective date of return to work

b. Have you released this worker to return to light duty?
No ☐ Yes ☐ effective date of return to work

c. What restrictions are placed on light duty return to work?

Lifting Bending

Standing Sitting

Other

d. If not released, how many days off work due to the work injury?

Licensed Healthcare Provider must sign before report is accepted
11. Signature

12. Phone | 13. Date

14. Attending Healthcare Provider Name

15. Address

City | State | ZIP

16. L&I Provider Number or NPI | 17. IRS Account #

DO NOT SEND THIS FORM TO

LABOR & INDUSTRIES

WEB ADDRESS TO CHECK FOR UPDATES OF FORM:
www.Lni.wa.gov/FormPub/Detail.asp?DocID=2467

NOTE: Beginning Jan. 1, 2013, injured workers will need to get ongoing care from a medical provider who is part of the L&I Medical Provider Network. They may see a non-network provider for the initial visit, but for additional or ongoing care, they will need to transfer to a network provider.

MAIL TO SELF-INSURED COMPANY

1. If the worker brings this form to your office, this box may be pre-printed. If you initiate the form in your office, obtain information from the worker.

2. Have the worker complete this box or obtain information from the worker.

ATTENDING HEALTH CARE PROVIDER INFORMATION

NOTICE: FAILURE TO FILE THIS REPORT WITHIN 5 DAYS FROM THE DATE OF TREATMENT MAY RESULT IN A PENALTY OF $250 IN ACCORDANCE WITH RCW 51.48.060.

3. This exam date.

4. Date you first treated patient for this injury/condition.
a) Insert ICD Dx coding which corresponds to narrative diagnosis in Box 3b.

b) Please list all diagnoses of conditions present which are result of incident or exposure. Also specify which side of body (right/left).

5. Indicate “Yes” or “No”. If “Yes”, list objective findings which support diagnosis. Do not restate diagnosis.

6. Indicate “Yes” or “No”. If “Yes”, specify study and complete findings if known.

7. Indicate treatment recommendations.

8. Specify name, address and phone number of health care provider to whom referred. Treatment beyond the initial visit must be done by providers enrolled in Washington’s workers compensation medical provider network. (This applies to workers of Self-Insured and State Fund employers.) Information to enroll in the network is available at JointheNetwork@Lni.wa.gov. If you choose not to enroll and your patient needs additional treatment, refer him or her to a network provider. The provider directory is available at www.Lni.wa.gov.

9. Indicate “Yes” or “No” and provide the additional information requested.

10. Indicate “Yes” or “No” and provide the additional information requested.

11. Signature of health care provider providing treatment and completing form.

12. Health care provider’s phone number.

13. Date health care provider signs report

14. Print or type your name as it appears on your Department of Labor and Industries payee account.

15. Indicate your full mailing address.

16. Indicate your Department of Labor and Industries issued provider number or NPI.

17. Provide your Internal Revenue Service reporting account number.

PATIENT INFORMATION

1. Leave blank.

2. Name of injured worker.

3. Worker’s phone number.

4. Worker’s mailing address or street address.

5. Worker’s social security number.

6. City, state and ZIP code of worker’s address.

7. Date worker was born.

8. Date accident occurred.

9. Time accident occurred.

10. Dates the worker missed work due to this injury.

11. Indicate -- M = Male F = Female

12A. Marital/Registered Domestic Partnership Status, e.g., M = Married, S = Single, D = Divorced, DP = Registered Domestic Partnership.

12B. Dependents -Number of dependents under age 18 (does not include spouse/domestic partner).

13. Brief description of accident or exposure by worker.

14. Medical Release Authorization. Worker’s signature authorizes the release of relevant medical information.

15. Statement of Responsibility - I have reported or will report this incident or exposure to my employer. If my claim is denied, I understand that I will be responsible for the care provided to me.

16. LEGAL NOTICE --RCW 51.48.020 (2) PROVIDES: ANY PERSON CLAIMING BENEFITS UNDER THIS TITLE WHO KNOWINGLY GIVES FALSE INFORMATION REQUIRED IN ANY CLAIM OR APPLICATION UNDER THIS TITLE SHALL BE GUILTY OF A FELONY, OR A GROSS MISDEMEANOR.

Dr. Morley Slutsky
Work Related Hearing Loss Evaluations

Scheduling: (800) 990 - 7924 Fax: (888) 418- 7997

Mailing Address
4580 Klahanie Dr. S.E., #125 Issaquah WA 98029

FREE WORK HISTORY: -WASHINGTON STATE ESD (EMPLOYMENT SECURITY DEPARTMENT)
Public Records Request
http://www.esd.wa.gov/newsandinformation/media/public-records-request.php

There are 4 ways to request a Washington State employment history:

Mail, Email, Phone, Fax

MAIL:
Employment Security Department
Records Disclosure Unit
Public Records Officer: Robert L. Page
P.O. Box 9046
Olympia, WA 98507-9046

EMAIL: recordsdisclosure@esd.wa.gov

PHONE: 844 766 8930
Records Disclosure unit is open 9 a.m. to 5 p.m., Monday through Friday, except on state holidays.

FAX: 866-610-9225

Be sure to include your Social Security Number with any request.

You can request that records be either mailed or faxed to you.

If you request your records to be faxed, make sure to **include your fax number**.

It may take several weeks to receive this information.

PROVIDED BY THE OFFICE OF DR. M. SLUTSKY

Employment Security Department
WASHINGTON STATE

SELF-REQUEST FOR RECORDS

A response to your request will be sent within 10 TO 15 BUSINESS DAYS.

1. PROVIDE THE FOLLOWING INFORMATION:

Name (please include any alias or maiden name):

Social Security Number:

2. CHECK ONE OR MORE BOXES TO INDICATE THE RECORDS BEING REQUESTED:

☐ I am requesting a copy of my Employment History from

(start date) through (end date)

☐ I am requesting a copy of my Unemployment Payment History from

(start date) through (end date)

☐ If you are seeking records other than the above (identify here):

3. AUTHORIZATION AND SIGNATURE:

a) Mail or Fax records to:

Name:

Contact Phone #:

Address Line:

City State Zip Code:

Return Fax #:

b) Send Request to:

Employment Security Department

Attn: Records Disclosure Unit

P.O. Box 9046

Olympia WA 98507-9046

Fax # (866)610-9225

Phone # (360) 725-9440

c) I authorize the requested information/records be released and sent to the entity identified in Section 3a.

d) By signing below I declare under the penalty of perjury under the laws of the State of Washington that I am the individual whose records are being requested.

Signature(Required) Date

Rev. 9/13

FROM OFFICE OF DR. M. SLUTSKY

Standard Form 180 (Rev. 10/10) (Page 1)
Prescribed by NARA (36 CFR 1228.168(b))
Authorized for local reproduction
Previous edition unusable
OMB No. 3095-0029 Expires 10/31/2011

REQUEST PERTAINING TO MILITARY RECORDS

* Requests from veterans or deceased veteran's next-of-kin may be submitted online by using eVetRecs at http://www.archives.gov/veterans/evetrecs/ *

(To ensure the best possible service, please thoroughly review the accompanying instructions before filling out this form. Please print clearly or type.)

SECTION I - INFORMATION NEEDED TO LOCATE RECORDS (Furnish as much as possible.)

1. NAME USED DURING SERVICE (last, first, and middle)	2. SOCIAL SECURITY NO.	3. DATE OF BIRTH	4. PLACE OF BIRTH

5. SERVICE, PAST AND PRESENT (For an effective records search, it is important that all service be shown below.)

	BRANCH OF SERVICE	DATE ENTERED	DATE RELEASED	OFFICER	ENLISTED	SERVICE NUMBER (If unknown, write "unknown")
a. ACTIVE COMPONENT						
b. RESERVE COMPONENT						
c. NATIONAL GUARD						

6. IS THIS PERSON DECEASED? If "YES" enter the date of death.
☐ NO ☐ YES _____

7. IS (WAS) THIS PERSON RETIRED FROM MILITARY SERVICE?
☐ NO ☐ YES

SECTION II – INFORMATION AND/OR DOCUMENTS REQUESTED

1. CHECK THE ITEM(S) YOU WOULD LIKE TO REQUEST A COPY OF:

☐ **DD Form 214 or equivalent.** This form contains information normally needed to verify military service. A copy may be sent to the veteran, the deceased veteran's next of kin, or other persons or organizations if authorized in Section III, below. NOTE: If more than one period of service was performed, even in the same branch, there may be more than one DD214. **Check the appropriate box below to specify a deleted or undeleted copy**. When was the DD Form(s) 214 issued? YEAR(S):

☐ **UNDELETED:** Ordinarily required to determine eligibility for benefits. Sensitive items, such as, the character of separation, authority for separation, reason for separation, reenlistment eligibility code, separation (SPD/SPN) code, and dates of time lost are usually shown.

☐ **DELETED:** The following items are deleted: authority for separation, reason for separation, reenlistment eligibility code, separation (SPD/SPN) code, and for separations after June 30, 1979, character of separation and dates of time lost.

☐ **All Documents in Official Military Personnel File (OMPF)**

☒ **Medical Records** (Includes Service Treatment Records (outpatient), inpatient and dental records.) If hospitalized, the facility name and date for each admission **must** be provided:

☒ **Other** (Specify):

2. PURPOSE: (An explanation of the purpose of the request is **strictly voluntary**; however, such information may help to provide the best possible response and may result in a faster reply. Information provided will in no way be used to make a decision to deny the request.) Check appropriate box:

☐ Benefits ☐ Employment ☐ VA Loan Programs ☐ Medical ☐ Medals/Awards ☐ Genealogy ☐ Correction ☐ Personal

☒ Other, explain: **Records to help with adjudication of WA State Dept of L&I claim for hearing loss due to noise exposure**

SECTION III - RETURN ADDRESS AND SIGNATURE

1. REQUESTER IS: (*Signature Required in # 3 below of veteran, next of kin, legal guardian, authorized government agent or "other" authorized representative. If "other" authorized representative, provide copy of authorization letter.)*

☐ Military service member or veteran identified in Section I, above

☐ Next of kin of deceased veteran **(Must provide proof of death)**.

Show relationship: _____

(See item 2a on accompanying instructions.)

☐ Legal guardian (Must submit copy of court appointment.)

☒ Other (specify) WA State Dept. of Labor and Industries

2. SEND INFORMATION/DOCUMENTS TO:
(Please print or type. See item 4 on accompanying instructions.)

Department of Labor and Industries

Name P.O. Box 44291

Street Apt.

Olympia WA 98504-4291

City State Zip Code

3. AUTHORIZATION SIGNATURE REQUIRED *(See items 2a or 3a on accompanying instructions.)* I declare (or certify, verify, or state) under penalty of perjury under the laws of the United States of America that the information in this Section III is true and correct.

Signature Required - Do not print

Date of this request

(800) 547 - 8367

Daytime phone

Email address

*This form is available at *http://www.archives.gov/research/order/standard-form-180.pdf* on the National Archives and Records Administration (NARA) web site.*

Department of Veterans Affairs

REQUEST FOR AND AUTHORIZATION TO RELEASE HEALTH INFORMATION

PRIVACY ACT INFORMATION: The execution of this form does not authorize the release of information other than that specifically described below. The information requested on this form is solicited under Title 38 U.S.C. The form authorizes release of information in accordance with the Health Insurance Portability and Accountability Act, 45 CFR Parts 160 and 164; 5 U.S.C. 552a; and 38 U.S.C. 5701 and 7332 that you specify. Your disclosure of the information requested on this form is voluntary. However, if the information including the last four of your Social Security Number (SSN) and Date of Birth (used to locate records for release) is not furnished completely and accurately, VA will be unable to comply with the request. The Veterans Health Administration may not condition treatment, payment, enrollment or eligibility on signing the authorization. VA may disclose the information that you put on the form as permitted by law. VHA may make a "routine use" disclosure of the information as outlined in the Privacy Act system of records notices identified as 24VA10P2 "Patient Medical Record – VA" and in accordance with the VHA Notice of Privacy Practices. VA may also use this information to identify Veterans and persons claiming or receiving VA benefits and their records, and for other purposes authorized or required by law.

TO: DEPARTMENT OF VETERANS AFFAIRS *(Name and Address of VA Health Care Facility)*

LAST NAME- FIRST NAME- MIDDLE INITIAL	LAST 4 SSN	DATE OF BIRTH

NOTE: Please fax the information to Dr. Slutsky's office at 888 418 7997

Dr. Morley Slutsky
4580 Klahanie Dr. SE,#125 Issaquah WA 98029
Office: (800) 871-8003 Fax: (888) 418 7997

VETERAN'S REQUEST

I request and authorize Department of Veterans Affairs to release the information specified below to the organization, or individual named on this request. I understand that the information to be released includes information regarding the following condition(s):

☐ DRUG ABUSE ☐ SICKLE CELL ANEMIA

☐ ALCOHOLISM OR ALCOHOL ABUSE ☐ TESTING FOR OR INFECTION WITH HUMAN IMMUNODEFICIENCY VIRUS *(HIV)*

DESCRIPTION OF INFORMATION REQUESTED

Check applicable box(es) and state the extent or nature of information to be provided:

☐ HEALTH SUMMARY *(Prior 2 Years)*

☐ INPATIENT DISCHARGE SUMMARY *(Dates)*: _____

☐ PROGRESS NOTES:

- ☐ SPECIFIC CLINICS *(Name & Date Range)*: _____
- ☐ SPECIFIC PROVIDERS *(Name & Date Range)*: _____
- ☐ DATE RANGE: _____

☐ OPERATIVE/CLINICAL PROCEDURES *(Name & Date)*: _____

☐ LAB RESULTS:

- ☐ SPECIFIC TESTS *(Name & Date)*: _____
- ☐ DATE RANGE: _____

☐ RADIOLOGY REPORTS *(Name & Date)*: _____

☐ LIST OF ACTIVE MEDICATIONS _____

☒ OTHER *(Describe)*: Please provide all medical evaluations pertaining to hearing loss, all diagnostic information pertaining to hearing loss (Hearing tests, MRI scans, etc.) and all Disability ratings reports pertaining to hearing loss.

PURPOSE(S) OR NEED

Information is to be used by the individual for:

☐ TREATMENT ☐ BENEFITS ☐ LEGAL ☐ OTHER *(Specify below)*

_____

LAST NAME- FIRST NAME- MIDDLE INITIAL	LAST 4 SSN	DATE OF BIRTH

AUTHORIZATION

I certify that this request has been made freely, voluntarily and without coercion and that the information given above is accurate and complete to the best of my knowledge. I understand that I will receive a copy of this form after I sign it. I may revoke this authorization in writing, at any time except to the extent that action has already been taken to comply with it. Written revocation is effective upon receipt by the Release of Information Unit at the facility housing records. Any disclosure of information carries with it the potential for unauthorized redisclosure, and the information may not be protected by federal confidentiality rules.

I understand that the VA health care provider's opinions and statements are not official VA decisions regarding whether I will receive other VA benefits or, if I receive VA benefits, their amount. They may, however, be considered with other evidence when these decisions are made at a VA Regional Office that specializes in benefit decisions.

EXPIRATION

Without my express revocation, the authorization will automatically expire.

☐ UPON SATISFACTION OF THE NEED FOR DISCLOSURE

☐ ON _____ *(enter a future date other than date signed by patient)*

☐ UNDER THE FOLLOWING CONDITION(S): _____

_____

PATIENT SIGNATURE *(Sign in ink)*	DATE *(mm/dd/yyyy)*
LEGAL REPRESENTATIVE SIGNATURE (*if applicable) (Sign in ink*)	DATE *(mm/dd/yyyy)*

PRINT NAME OF LEGAL REPRESENTATIVE	RELATIONSHIP TO PATIENT

FOR VA USE ONLY

TYPE AND EXTENT OF MATERIAL RELEASED

DATE RELEASED	RELEASED BY: