

Known or Suspected Occupational Disease Report

(Information will be held confidential as prescribed in Act.)

EMPLOYEE AFFECTED

Name (Last, First, Middle)	Age	Sex M F	Race: <input type="radio"/> White <input type="radio"/> Black <input type="radio"/> Hispanic <input type="radio"/> Other
Street	City	State	Zip
Home Phone Number	Last Four Digits of Social Security Number (Optional)		

CURRENT EMPLOYER

Current Employer Name	Worksite County		
Worksite Address	City	State	Zip
Business Phone	If Known, Indicate Business Type (products manufactured or work done)		
Number of Employees <input type="radio"/> < 25 <input type="radio"/> 25-100 <input type="radio"/> 100-500 <input type="radio"/> > 500			
Employee's Work Unit/Department	Dates of Employment From: _____ To: _____ Mo Day Year Mo Day Year		
Employee's Job Title or Description of Work			

ILLNESS INFORMATION

Nature of Illness or Health Condition (Examples: Headache, Nausea, Difficulty Breathing, Cough, etc.)	Date of Diagnosis _____ Mo Day Year	
Suspected Causative Agents (Chemicals, Physical Agents, Conditions)	Did Employee Die? Yes <input type="radio"/> No <input type="radio"/>	If Yes, Date of Death _____ Mo Day Year
If Physician, Indicate Clinical Impression for Suspected Occupational Disease, or Diagnosis of Confirmed Occupational Disease		

ADDITIONAL COMMENTS

_____ _____

REPORT SUBMITTED BY

If Report Submitted by Non-Physician, Did Employee See a Physician? <i>If yes, record information below.</i>	Yes <input type="radio"/> No <input type="radio"/> Don't Know <input type="radio"/>
Physician's Name	Phone
Office Address	City State Zip
Name of Person Submitting Report	Physician <input type="radio"/> Non-Physician <input type="radio"/>
Address	City State Zip
Signature	Phone Date

The Michigan Department of Licensing Regulatory Affairs is an equal opportunity, affirmative action employer, service provider and buyer.

Return completed form to:

Michigan Department of Licensing and Regulatory Affairs
Michigan Occupational Safety and Health Administration
Management and Technical Services Division
7150 Harris Drive, P.O. Box 30649
Lansing, MI 48909-8149

BACKGROUND AND INSTRUCTIONS FOR COMPLETING KNOWN OR SUSPECTED OCCUPATIONAL DISEASE REPORT

As a result of Executive Orders No. 1996-1, 1996-2 and 2003-18 and Part 56 of P.A. 368 of 1978, a physician, hospital, clinic or employer must report known or suspected cases of occupational diseases or workplace aggravated health conditions to the Michigan Department of Licensing and Regulatory Affairs within 10 days after discovery of the disease or condition on a report form furnished by the department. This requirement does not apply to occupational injuries.

This report is furnished by the Department of Licensing and Regulatory Affairs in accordance with Section 5611 (4) of P.A. 368 of 1978 and is required to be completed and submitted to the Department of Licensing and Regulatory Affairs at the address below for all such cases to fulfill the statutory mandate prescribed by Section 5611 or Part 56 of the Act.

Instructions for completing report:

General:

Multiple reports on the same individual for the same illness should not be submitted. The employer should return this form only if the employee is not referred to a physician, hospital, or clinic. If a physician returns the form indicating a suspected occupational disease and at a later date confirms this occupational disease, an updated form confirming their diagnosis and causative agent should be submitted.

Employers:

If an employer is submitting the form, all questions, with the exception of those indicated for physicians only, should be completed. The form should be completed by the employer at the time of onset, discovery, or suspected occurrence of the employee's illness and returned directly to Michigan Department of Licensing and Regulatory Affairs.

If the employee is referred to a physician, hospital, or clinic, the employer should complete the forms as stated above and the form should then accompany the employee for completion by the medical personnel.

Physician, hospital or clinic:

The questions on the form, with the exception of those indicated for physicians only, may be completed by the employer at the time of onset, discovery, or suspected occurrence of the employee's illness. The form should then accompany the employee at the time of referral to a physician, hospital, or clinic for medical evaluation where the remainder of the form should be completed and submitted to the Michigan Department of Licensing and Regulatory Affairs. If the employee is seen by the physician without a referral from the employer, and the physician diagnoses a suspected or confirmed occupational illness, the entire form is to be completed by the physician and submitted to the Michigan Department of Licensing and Regulatory Affairs.

It is the responsibility of the employer and of physicians, hospitals, and clinics to ensure that the form is properly completed, signed and submitted to the Michigan Department of Licensing and Regulatory Affairs within 10 days after the onset of the disease, suspected occurrence of the disease, or a workplace aggravated health condition. The form must be completed for all suspected or actual occupational diseases or health conditions aggravated by workplace exposure, including death of the employee as a result of the disease or health condition aggravated by workplace exposure.

Completion of this report form does not relieve the employer of the requirements of notification fatalities and catastrophes and to maintain records of each recordable occupational injury or illness pursuant to the requirements of Public Act 154 of 1974, as amended, the Michigan Occupational Safety and Health Act.

ADDITIONAL REPORT FORMS ARE AVAILABLE FROM THE MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS

**Michigan Department of Licensing and Regulatory Affairs
Michigan Occupational Safety and Health Administration
Management and Technical Services Division
7150 Harris Drive, P.O. Box 30649
Lansing, Michigan 48909-8149
(517) 322-1817**