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APPLICATION FOR CHRISTOPHER R. SLEZAK FIRST RESPONDER PRESUMED COVERAGE FUND

Michigan Department of Labor and Economic Opportunity
Funds Administration
P.O. Box 30182, Lansing, MI 48909

1. NAME OF EMPLOYEE (Last, First, MI)			2. SOCIAL SECURITY NUMBER	3. DATE OF BIRTH
4. STREET NUMBER AND NAME			8. TAX FILING STATUS ☐ A. Single ☐ C. Married, Filing Joint ☐ B. Single, Head of Household ☐ D. Married, Filing Separate	
5. CITY	6. STATE	7. ZIP CODE		
			9. DATE OF DEATH (If Applicable)	
10. NAME OF DEPENDENTS			11. RELATIONSHIP TO EMPLOYEE	12. BIRTH DATE
13. NAME OF EMPLOYER			14. DATES OF EMPLOYMENT FROM: TO:	
15. FEDERAL I.D. NUMBER (If Known)			16. EARNINGS $ ☐ Hourly ☐ Weekly	
17. STREET ADDRESS			18. CITY	19. STATE / 20. ZIP CODE

21. ARE YOU CURRENTLY OR HAVE YOU EVER BEEN IN FULL-TIME ACTIVE SERVICE OF THIS EMPLOYER? ☐ YES ☐ NO
ARE YOU A CURRENT OR FORMER PART-TIME, PAID ON-CALL; VOLUNTEER OF THIS EMPLOYER? ☐ YES ☐ NO
ARE YOU A CURRENT OR FORMER FOREST FIRE OFFICER/CRASH RESCUE OFFICER OF THIS EMPLOYER? ☐ YES ☐ NO

IF NO, PLEASE EXPLAIN:_____

BRIEF JOB DESCRIPTION:_____

NAME OF SUPERVISOR _____ PHONE_____ EMAIL (if known)_____

22. IN THE COURSE OF YOUR EMPLOYMENT WITH THE FIRE DEPARTMENT/FIRE AUTHORITY WERE YOU EXPOSED TO THE HAZARDS INCIDENTAL TO FIRE SUPPRESSION, RESCUE, OR EMERGENCY MEDICAL SERVICES? ☐ YES ☐ NO

23. HAVE YOU FILED A CLAIM AGAINST THE EMPLOYER IN NUMBER 14? ☐ YES ☐ NO

24. HAVE YOU FILED AN APPLICATION FOR MEDIATION OR HEARING (WC104A) AGAINST THE EMPLOYER IN NUMBER 14? ☐ YES ☐ NO

25. HAVE YOU BEEN DIAGNOSED WITH RESPIRATORY TRACT, BLADDER, SKIN, BRAIN, KIDNEY, BLOOD, THYROID, TESTICULAR, PROSTATE, LYMPHATIC, OVARIAN, BREAST OR NON-HPV CERVICAL CANCER ☐ YES ☐ NO
IF YES, TYPE:

DATE OF INITIAL MEDICAL APPOINTMENT RELATED TO DIAGNOSIS:_____ DATE OF DIAGNOSIS:_____

26. FATHER ☐ ALIVE (AGE____) ☐ DECEASED (AGE_____) ☐ UNKNOWN CAUSE OF DEATH:_____ ☐ UNKNOWN
MOTHER ☐ ALIVE (AGE____) ☐ DECEASED (AGE_____) ☐ UNKNOWN CAUSE OF DEATH:_____ ☐ UNKNOWN

27. ARE YOU CURRENTLY OR HAVE YOU EVER BEEN A TOBACCO USER? If Yes, proceed to the following: ☐ YES ☐ NO
AT WHAT AGE DID YOU FIRST USE TOBACCO?_____
IF YOU HAVE QUIT, PLEASE PROVIDE DATE_____
PLEASE DESCRIBE TOBACCO USE_____
_____

28. ARE YOU RECEIVING A PENSION? ☐ YES ☐ NO
IF YES, PLEASE ADVISE THE TYPE OF PENSION: REGULAR OR DISABILITY (circle one)
IF NO, HAVE YOU APPLIED FOR A PENSION? ☐ YES ☐ NO
HAS YOUR PENSION APPLICATION BEEN DENIED? ☐ YES ☐ NO

29. LIST THE NAMES AND ADDRESSES OF ALL DOCTORS, HOSPITALS AND OTHER HEALTH CARE PROVIDERS. (ATTACH A SEPARATE SHEET IF NECESSARY)

NAME	ADDRESS (Street Number and Name)	CITY	STATE	ZIP CODE

30. HAVE YOU HAD ANY EMPLOYMENT SINCE THE DATE OF INJURY? ☐ YES ☐ NO

IF YES, LIST THE NAME AND ADDRESS OF THE EMPLOYER.

☐ I UNDERSTAND MAKING OF THIS CLAIM CONSTITUTES A SUSPENSION OF MY CLAIM AGAINST MY EMPLOYER.

Making a false or fraudulent statement for the purpose of obtaining or denying benefits can result in criminal or civil prosecution, or both, and denial of benefits.

The submission of this application does not guarantee the right to benefits under the Workers' Disability Compensation Act.

SIGNATURE OF EMPLOYEE	TELEPHONE NUMBER	EMAIL ADDRESS	DATE

ATTORNEY IDENTIFICATION

NAME OF ATTORNEY	NAME OF LAW FIRM	ATTORNEY ID **P.**	
ADDRESS (STREET NUMBER AND NAME)	CITY	STATE	ZIP CODE
SIGNATURE OF ATTORNEY	TELEPHONE NUMBER	DATE	

LEO is an equal opportunity employer/program. Auxiliary aids, services and other reasonable accommodations are available upon request to individuals with disabilities.

AUTHORITY: Workers' Disability Compensation Act
COMPLETION: Mandatory MCL 418.405
PENALTY: None

For additional information regarding the fund, including eligibility requirements, visit the Workers' Disability Compensation Agency's website at www.michigan.gov/wdca.