FILE NAME: Kentile (KEN)

DATE: 2002 Dec 16

DOC#: KEN025

DOCUMENT DESCRIPTION: Workers Compensation Documents with Cover Letter

HARRIS BEACH LLP
ATTORNEYS AT LAW

805 THIRD AVENUE
NEW YORK, NEW YORK 10022
(212) 687-0100
(212) 687-0659 FAX

LISA M. PASCARELLA, ESQ.
DIRECT: (212) 212-313-5412
lpascarella@harrisbeach.com

December 16, 2002

Via FedEx (Tracking No. 8372 0197 6217)

Richard Meadow, Esq.
Weitz & Luxenberg
180 Maiden Lane
New York, New York 10038

Re: Kentile Discovery
Jacques Weinstock
NYCAL Index No.: 110500-01
Our File No.: 187610

Dear Rick:

Enclosed please find redacted Workers Compensation records responsive to demands numbered 8 and 10 of your firm's discovery and inspection letter dated October 29, 2002. Please be advised that these documents are being turned over to you over vehement objection. Please also be advised that Kentile Floors, Inc. reserves all objections as set forth in my correspondence of December 12, 2002, and reserves all rights to make the appropriate motions *in limine* and otherwise at the appropriate time.

Should you have any questions or concerns please do not hesitate to contact the undersigned.

Very truly yours,

LISA M. PASCARELLA

LMP/amv
Encl:

cc:

Special Master Laraine Pacheco (w/o encl)

50358

PLAINTIFF'S EXHIBIT
KEN-513

STATE OF ILLINOIS
INDUSTRIAL COMMISSION
100 NORTH LA SALLE STREET
CHICAGO, ILLINOIS 60601

NOTICE OF HEARING

NOTICE IS HEREBY GIVEN THAT AN APPLICATION FOR ADJUSTMENT OF CLAIM WAS FILED WITH THE ILLINOIS INDUSTRIAL COMMISSION

MAIL TO

KENTILE FLOORS INC
4532 S KOLIN
CHICAGO IL 60632

THIS IS A LEGAL DOCUMENT WHICH MUST BE FORWARDED IMMEDIATELY TO YOUR INSURANCE CARRIER OR ATTORNEY. FAILURE TO RESPOND MAY RESULT IN A JUDGMENT BEING ENTERED AGAINST YOU.

ASSIGNED TO ARBITRATOR AUM, HERBERT

REPORT TO ASSIGNMENTS (RM 1303) FIRST

PETITIONER	NOTICE DATE	CASE FILED	CASE NUMBER
[redacted]	06/23/84	06/21/84	84 CD 000438
PETITIONER'S ATTORNEY	**SOCIAL SECURITY #**	**ACCIDENT DATE**	**LOCATION OF ACCIDENT**
MICHAEL FIORITO/M SIEMAN	[redacted]/21/83		CHICAGO IL
INJURED EMPLOYEE'S NAME			

RESPONDENT	ATTORNEY
KENTILE FLOORS INC 4532 S KOLIN CHICAGO IL 60632	
RESPONDENT	**ATTORNEY**
	ATTORNEY

HEARING TYPE	DATE	LOCATION	
INITIAL STATUS	09/04/84	160 N LASALLE ASSIGNMENTS-ROOM 1303 CHICAGO IL 60601	
	TIME		
	10:00AM		

COMPANION CASES

	ATTORNEY

FURTHER TAKE NOTICE THAT THE ABOVE ENTITLED CAUSE IS SCHEDULED FOR HEARING BEFORE THE ILLINOIS INDUSTRIAL COMMISSION AS STATED ABOVE AT WHICH TIME ALL PARTIES OR THEIR COUNSEL MUST APPEAR. ALL PERTINENT DOCUMENTS, RECORDS, OR OTHER INFORMATION SHOULD BE AVAILABLE TO COUNSEL, PRIOR TO THE HEARING DATE.

TO BE COMPLETED BY ATTORNEY FOR EMPLOYER. DO NOT DETACH.

ATTORNEY'S AFFIDAVIT RULE 2-(3). FILE ONE COPY WITH COMMISSION AT ONCE.
I HEREBY CERTIFY THAT I HAVE NOT DIRECTLY OR INDIRECTLY SOLICITED EMPLOYMENT BY THE ABOVE NAMED PARTY, AND KNOW OF NO SOLICITATION OF SAID PARTY BY ANY PERSON THAT HAS RESULTED IN THE EMPLOYMENT OF MYSELF OR ANY MEMBER OF MY FIRM.

ATTORNEY (Please Print Name) _____ ATTORNEY SIGNATURE _____

FIRM NAME _____ TELEPHONE NO. _____

FIRM'S ADDRESS _____

☐ THE ABOVE SIGNED ENTERS HIS/HER APPEARANCE ON BEHALF OF THE RESPONDENT. SERVED TO:

MICHAEL FIORITO/M SIEMAN
135 S LASALLE ST #1455

FORM 45: **Employers First Report of Injury or Illness**

PLEASE TYPE OR PRIN

Filing of this report does not affect your liability under the Workers' Compensation Act and is not incriminatory in any sense

	*45 ILLINOIS UNEMPLOYMENT COMPENSATION NUMBER	[illegible]341	DATE OF REPORT	MONTH [illegible] DAY 22 YEAR [illegible]	CASE OR FILE NUMBER	
B	EMPLOYER'S NAME: Mantile Floors Inc.				Is this a lost workday case? ☐Yes ☐No	
C	DOING BUSINESS UNDER THE NAME OF: Mantile Floors Inc.		CITY, STATE: Chgo, Ill.		ZIP CODE: 60632	
D	MAIL ADDRESS: [illegible] S. Kilpatrick Ave.		CITY, STATE: Chgo, Ill.		ZIP CODE: [illegible]	
E	EMPLOYER LOCATION IF DIFFERENT FROM MAIL ADDRESS					
F	NATURE OF BUSINESS OR SERVICE: [illegible] Manufacturing	SIC CODE: 3292	TOTAL NUMBER OF EMPLOYEES AT THE LOCATION WHERE ILLNESS OR INJURY OCCURRED: 330			
G	NAME OF WORKERS' COMP. INSURANCE CARRIER: [illegible] Mutual Ins. Group	POLICY NUMBER: 950 [illegible]43	SELF INSURED: YES ☐ NO ☐	COUNTY WHERE INJURY OCCURRE		
H	EMPLOYEE'S NAME (LAST, FIRST, MIDDLE): [redacted]		SOCIAL SECURITY NUMBER: [redacted]			
I	HOME ADDRESS: [redacted]	CITY, STATE: [redacted]	ZIP CODE: [redacted]			
J	MALE ☒ FEMALE ☐ MARRIED ☐ SINGLE ☐ WIDOW(ER) ☐ DIVORCED ☐	BIRTH DATE: MONTH 11 DAY 22 YEAR [illegible]	NUMBER OF DEPENDENT CHILDREN UNDER 18 AT TIME OF INJURY OR ILLNESS			
K	DATE AND TIME OF THE INJURY OR EXPOSURE: Allegedly 4-21-83 MONTH DAY YEAR a.m. p.m.	EMPLOYEE'S AVERAGE WEEKLY EARNINGS: $	LAST DAY EMPLOYEE WORKED: MONTH 5 DAY 6 YEAR 83			
L	JOB TITLE OR OCCUPATION: Maint. Man.	DEPARTMENT NORMALLY ASSIGNED: Maintenance				
M	ADDRESS OF LOCATION WHERE INJURY OR EXPOSURE OCCURRED	CITY, STATE	ZIP CODE			
N	DID EMPLOYEE DIE AS A RESULT OF THE INJURY OR ILLNESS? YES ☐ NO ☒	IF EMPLOYEE DIED AS A RESULT OF THE INJURY OR ILLNESS, GIVE DATE OF DEATH	MONTH DAY YEAR			
O	WAS THE INJURY OR EXPOSURE ON THE EMPLOYER'S PREMISES? Alleged ☐YES ☐NO	DID THIS INCIDENT RESULT IN: Alleged ☐ OCCUPATIONAL INJURY ☐ OCCUPATIONAL DISEASE	Was Employee given Industrial Commission Handbook? YES ☐ NO ☐			
P	NATURE OF THE INJURY: Alleged.					
Q	PART OF THE BODY AFFECTED (BE SPECIFIC): Alleged lungs, legs.					
R	WHAT TASK WAS EMPLOYEE PERFORMING WHEN ILLNESS OR INJURY OCCURRED? Maint. Mechanic / Lead Man.					
S	OBJECT OR SUBSTANCE RESPONSIBLE FOR INJURY OR ILLNESS (SOURCE): Alleged exposure to asbestos fibers and related materials.					
T	HOW DID ACCIDENT OR ILLNESS OCCUR (TYPE)? Alleged exposure to asbestos fibers and related materials.					
U	WHAT HAZARDOUS CONDITIONS, METHODS OR LACK OF PROTECTIVE DEVICES CONTRIBUTED? None.					
V	WHAT UNSAFE ACT BY A PERSON CAUSED OR CONTRIBUTED TO THE INJURY OR ILLNESS? None.					
W	HAVE MEDICAL SERVICES BEEN RENDERED TO THE EMPLOYEE? YES ☐ NO ☒	IS OR HAS THE EMPLOYEE BEEN HOSPITALIZED? YES ☐ NO ☒				
X	NAME AND ADDRESS OF PHYSICIAN	CITY, STATE	ZIP CODE			
Y	NAME AND ADDRESS OF HOSPITAL	CITY, STATE	ZIP CODE			
	REPORT PREPARED BY: (NAME—PRINT OR TYPE) Litaez	SIGNATURE	TITLE AND TELEPHONE NUMBER			

SP363715

CIDENT REPORTING DEPT., ILLINOIS INDUSTRIAL COMMISSION, 160 North LaSalle Street, Chicago, Illinois 6060

NOTE: DISCLOSURE OF THIS INFORMATION TO THE INDUSTRIAL COMMISSION IS MANDATORY UNDER IL. REV. STAT. CH.

KENTILE FLOORS INC.
58 Second Avenue
Brooklyn, N.Y. 11215

PULMONARY FUNCTION EVALUATION

Name [redacted] Sex M

Date 5/20/77 Age 56

Address _____ Height (inches) 66

Smoking History 1 Packs/day Years 40 yrs Weight (lbs.) 154

Additional History Ex-pt UNL

Ventilation	Predicted	Actual	% Predicted
FVC	4.12	2.97	72.0
FEV1	3.02	1.71	56.6
FEV1/FVC		57.5	
PEF		6.31	
FEF 25-75	3.09	0.75	24.2

INTERPRETATION:

Mild ~~Obstructive~~ Restrictive
Mod. Obstructive
& Severe Small airway Disease

Nisar A. Quraishi M.D.

3/3/77.

Patient advised of the findings of:

Complains of congestion in the chest & low back pain

Heart Rhythm BP. 95/60

Lungs - Moist at bases

Ext - Posterior Edema

Pulmonary Function Test ☐

Chest X-ray ☐

taken on _____

Patient was advised that further examinations are indicated by his doctor to establish a final diagnosis. Patient advised that a copy of these reports would be sent to his doctor at his request.

Advised to see his P.M.D. for the above.

[redacted]

L. Quinones RN

JOSEPH N. SAVINO, M. D., P.C.
168 CLINTON STREET
BROOKLYN, NEW YORK 11201
875-7744

March 3, 1977

Re: [redacted]

Dear Dr. Quraishi:

RADIOGRAPHIC EXAMINATION: CHEST PA

There is no evidence of acute, recent or progressive pulmonary pathology.

The cardiac, hilar and mediastinal shadows are normal for the patient's stated age and habitus.

The visualized osseous structures and soft tissue components of the thorax are intact.

IMPRESSION: Negative radiographic examination of the chest.

Sincerely,

Joseph N. Savino M.D. P.C.

Joseph N. Savino, M.D., P.C.

JNS/fs
films to Dr. Quraishi
Kentile Floors

CPR CENTERS

BROOKLYN HEIGHTS CARDIO-PULMONARY REHABILITATION ASSOCIATES
164 CLINTON STREET
BROOKLYN, NEW YORK 11201

TELEPHONE
(212) 237-2814
(212) 237-2815

VENTILATION SCREENING

Dear Dr. Savins

Your patient [redacted] was examined on 2/26/76

and the following results were obtained.

	OBSERVED	PREDICTED	% OF NORMAL
FORCED VITAL CAPACITY IN LITERS	2.1	3.98	52%
FEV 1	1.475		70%
FEV 3	1.975		94%

These findings indicate:

Definite restrictive disease but no obstructive disease.

Thank you for referring Mr. [redacted] to us.

Sincerely,

S. Cutler

Dr. S. Cutler

SP424605

JOSEPH N. SAVINO, M. D., P.C.
168 CLINTON STREET
BROOKLYN, NEW YORK 11201
875-7744

December 19, 1975

Re: [redacted]

Dear Dr. Greco:

RADIOGRAPHIC EXAMINATION: CHEST PA

There is no evidence of acute, recent or progressive pulmonary pathology.

The cardiac, hilar and mediastinal shadows are normal for the patient's stated age and habitus.

The visualized osseous structures and soft tissue components of the thorax are intact.

IMPRESSION: Negative radiographic examination of the chest.

Sincerely,

Joseph N. Savino, M.D., P.C.

JNS/ fs
films to Dr. Greco
(12/23/75)

BROOKLYN TUBERCULOSIS AND RESPIRATORY DISEASE ASSOCIATION, INC.

293 SCHERMERHORN STREET • BROOKLYN, N. Y. 11217 • 624-8531

SP424507

RESPIRATORY DISEASE SCREENING REPORT

Date: 1-14-75 Height 5'6" Weight 167

Name: Last [redacted] First [redacted] Initial ____ Age 54 Sex M

Address: [redacted] Zip Code [redacted]

Occupation: Present Delicatessen Owner Previous ____

Personal Physician: ____ Referred by: MD

Address: ____

X-RAY FINDINGS: No pathological findings

PULMONARY FUNCTION TEST FINDINGS: V.C. 2200 cc. FEV_1 1200 cc. Mod to severe restrictive + severe obstructive pattern

QUESTIONNAIRE

SYMPTOMS:

Do you cough every day? yes What time of day? ✓ A.M. ✓ P.M.

Have you recently had a cough that lasted 3 weeks or more? yes

During the past two years, have you had a cough lasting 3 months or more? yes

Have you ever coughed up blood? NO How much? ____ When? ____

Do you cough up phlegm? once in awhile

How much in 24 hours? 1 tbsp. ____ 2 tbsp. ____ More ____ Less ____

Color: White ✓ Yellow ✓ Green ____

Are you usually short of breath? NO

Are you short of breath after exercise or exertion? NO

Can you walk up two flights of stairs without shortness of breath? yes

Do you have a whistle or wheezing in your chest? yes

ILLNESSES:

In the past have you ever had:

Heart trouble? ____

A chest disease? NO What kind? ____

A chest operation? NO What kind? ____

PATIENT ADVISED OF THE FINDINGS OF THIS EXAMINATION 2-10-75 MD

Has a physician told you that you have:

Bronchitis? ____ Hay Fever? NO Other chest disease? ____

Emphysema? NO Pleurisy? NO Specify ____

Asthma? NO Tuberculosis? ____

SMOKING HISTORY:

Do you smoke? yes What? cigarettes 1 pk. a day

If cigarettes, how much: Less than 20 cigarettes a day? ____ How many packs? ____

Have you ever smoked? ____

At what age did you begin smoking? 15 When did you stop? ____

BROOKLYN TUBERCULOSIS & RESPIRATORY DISEASE ASSOCIATION, INC.
293 SCHERMERHORN STREET, BROOKLYN, N. Y. 11217 (212) 624-8531

Jan. 3,1974.

John J. Greco, M.D.
Kentile Floors Inc.
58 - 2nd Avenue
Brooklyn,N.Y. 11215

RE: [redacted]
AGE: 53
16 - Lefferts Place

Dear Doctor:

The chest X-ray which was taken of the above named person on Dec. 27,1973 was read by a qualified chest specialist and showed:

NO PATHOLOGICAL FINDINGS.

Thank you for your referral.

Sincerely yours,

Agnes E. Gerding

Agnes E. Gerding
Program Director

AEG/an

BROOKLYN TUBERCULOSIS & RESPIRATORY DISEASE ASSOCIATION, INC.
293 SCHERMERHORN STREET, BROOKLYN, N. Y. 11217 (212) 624-8531

Jan. 22,1975.

John J. Greco, M.D.
Kentile Floors Inc.
58 - 2nd Avenue
Brooklyn,N.Y. 11215

RE: [redacted]59
AGE: 54
16 - Lefferts Place

Dear Doctor:

The chest X-rays which were taken of the above named person on Jan. 14,1975 were read by a qualified chest specialist and showed:

PA VIEW- NO PATHOLOGICAL FINDINGS.

LEFT LATERAL VIEW- NO PATHOLOGICAL FINDINGS.

RIGHT LATERAL VIEW- NO PATHOLOGICAL FINDINGS.

Sincerely yours,

Agnes E Gerding

AEG/an

Agnes E. Gerding
Program Director

PATIENT ADVISED OF
THE FINDINGS OF
THIS EXAMINATION
2-10-75
88

BROOKLYN TUBERCULOSIS & RESPIRATORY DISEASE ASSOCIATION, INC.
293 SCHERMERHORN STREET, BROOKLYN, N. Y. 11217 (212) 624-8531

Jan. 27,1975.

RE: [redacted]
AGE: 54
16 - Lefferts Place

Dear Doctor:

Attached is the Respiratory Disease Screening Report of the above named patient. You will have already received this patient's X-ray report.

The pulmonary function screening test was interpreted by a qualified pulmonary physiologist. It indicates further examinations are needed to establish a final diagnosis.

Sincerely yours,

Agnes E. Gerding

Agnes E. Gerding
Program Director

AEG/an

PATIENT ADVISED OF THE FINDINGS OF THIS EXAMINATION
KS
2-10-75

BROOKLYN TUBERCULOSIS & RESPIRATORY DISEASE ASSOCIATION, INC.
293 SCHERMERHORN STREET, BROOKLYN, N. Y. 11217 (212) 624-8531

DATE: 1/27/75.

TO: Brooklyn Tuberculosis & Respiratory Disease Association

FROM:

RE: [redacted] AGE: 54 16 - [redacted]

The test findings of the above named person indicate a need for further study.

Your cooperation in returning this report will aid us in evaluating our work and enable us to give you better service.

REPORT

The above named patient has been examined by me and the following diagnosis is my impression.

_____ Negative for tuberculosis

_____ Tuberculosis - active

_____ Tuberculosis - activity undetermined

_____ Tuberculosis - inactive-receiving treatment

_____ Tuberculosis - inactive-not receiving treatment

_____ Chronic Bronchitis

_____ Emphysema

_____ Pulmonary Fibrosis

_____ Malignancy

_____ Cardiac Abnormalities

_____ Other abnormal conditions (please specify)

PT. NOT ADVISED OF THE FINDINGS OF THIS EXAMINATION
BS
2-10-75

Signed: _____

Additional information may be reported on the reverse side.

BROOKLYN TUBERCULOSIS & RESPIRATORY DISEASE ASSOCIATION, INC.
293 SCHERMERHORN STREET, BROOKLYN, N. Y. 11217 (212) 624-8531

Jan. 21,1974.

RE: [redacted]
AGE: 53
[redacted]

Dear Doctor:

Attached is the Respiratory Disease Screening Report of the patient you referred to the Association's Chest X-Ray Center. You will have already received this patient's chest X-ray report.

The pulmonary function screening test was interpreted by a qualified pulmonary physiologist. It indicates that further examinations are needed to establish a final diagnosis.

Information on your findings will help us evaluate our services. We would appreciate your returning the enclosed form.

Sincerely yours,

Agnes E. Gerding

Agnes E. Gerding
Program Director

AEG/an

BROOKLYN TUBERCULOSIS AND RESPIRATORY DISEASE ASSOCIATION, INC.

293 SCHERMERHORN STREET • BROOKLYN, N. Y. 11217 • 624-8331

RESPIRATORY DISEASE SCREENING REPORT

Date: 12/27/73 Height 5'1/6" Weight 160

Name: Last [redacted] First [redacted] Initial ____ Age 53 Sex M

Address: [redacted] Zip Code ____

Occupation: Present Retired Previous ____

Personal Physician: ____ Referred by: ____

Address: ____

X-RAY FINDINGS: No pathological findings

PULMONARY FUNCTION TEST FINDINGS: V.C. 2200. Moderate restrictive pattern no obstructive pattern

QUESTIONNAIRE

SYMPTOMS:

Do you cough every day? YES What time of day? ____ A.M. ____ P.M.

Have you recently had a cough that lasted 3 weeks or more? YES

During the past two years, have you had a cough lasting 3 months or more? YES

Have you ever coughed up blood? NO How much? ____ When? ____

Do you cough up phlegm? YES

How much in 24 hours? 1 tbsp. ____ 2 tbsp. ____ More ____ Less ✓

Color: White ____ Yellow ✓ Green ____

Are you usually short of breath? YES

Are you short of breath after exercise or exertion? NO

Can you walk up two flights of stairs without shortness of breath? YES

Do you have a whistle or wheezing in your chest? YES

ILLNESSES:

In the past have you ever had:

Heart trouble? ____

A chest disease? NO What kind? ____

A chest operation? ____ What kind? ____

Has a physician told you that you have:

Bronchitis? ✓ Hay Fever? ____ Other chest disease? ____

Emphysema? ____ Pleurisy? ____ Specify ____

Asthma? ____ Tuberculosis? ____

SMOKING HISTORY:

Do you smoke? YES What? Cigarettes

If cigarettes, how much: Less than 20 cigarettes a day? NO How many packs? 1

Have you ever smoked? ____

At what age did you begin smoking? 16 When did you stop? ____

3M-4/73

BROOKLYN TUBERCULOSIS & RESPIRATORY DISEASE ASSOCIATION, INC.
293 SCHERMERHORN STREET, BROOKLYN, N. Y. 11217 (212) 624-8531

DATE: 1/21/74.

TO: Brooklyn Tuberculosis & Respiratory Disease Association

FROM:

RE: [redacted] AGE: 53 [redacted]

The test findings of the above named person indicate a need for further study.

Your cooperation in returning this report will aid us in evaluating our work and enable us to give you better service.

REPORT

The above named patient has been examined by me and the following diagnosis is my impression.

_____ Negative for tuberculosis

_____ Tuberculosis - active

_____ Tuberculosis - activity undetermined

_____ Tuberculosis - inactive - receiving treatment

_____ Tuberculosis - inactive - not receiving treatment

_____ Chronic Bronchitis

_____ Emphysema

_____ Pulmonary Fibrosis

_____ Malignancy

_____ Cardiac Abnormalities

_____ Other abnormal conditions (please specify)

Signed:_____

Additional information may be reported on the reverse side.

BROOKLYN TUBERCULOSIS & RESPIRATORY DISEASE ASSOCIATION, INC.
293 SCHERMERHORN STREET, BROOKLYN, N. Y. 11217 (212) 624-8531

Dec. 21, 1972.

John J. Greco, M.D.
Kentile Floors Inc.
58 - 2nd Avenue
Brooklyn, N.Y. 11215

RE: [redacted]
AGE: 53
16 [redacted]

Dear Doctor:

The chest X-ray which was taken of the above named person on Dec. 14, 1972, was read by a qualified chest specialist and showed:

NO PATHOLOGICAL FINDINGS.

Thank you for your referral.

Sincerely yours,
Agnes E. Gerding
Agnes E. Gerding
Program Director

AEG/an

BROOKLYN TUBERCULOSIS & RESPIRATORY DISEASE ASSOCIATION, INC.
293 SCHERMERHORN STREET, BROOKLYN, N.Y. 11217 (212) 624-8531

Dec. 21,1972.

John J. Greco, M.D.
Kentile Floors Inc.
58 - 2nd Avenue
Brooklyn,N.Y. 11215

RE: [redacted]N
AGE: 53 [redacted]

Dear Doctor:

Attached is the Respiratory Disease Screening Report of the patient you referred to the Association's Chest X-Ray Center. You will have already received this patient's screening chest X-ray and report.

The pulmonary function screening test was interpreted by a qualified pulmonary physiologist. It indicates that further examinations are needed to establish a final diagnosis.

Information on your findings will help us evaluate our services. We would appreciate your returning the enclosed form.

Sincerely yours,

Agnes E. Gerding
Program Director

encl.

7.

BROOKLYN TUBERCULOSIS AND RESPIRATORY DISEASE ASSOCIATION, INC.

293 SCHERMERHORN STREET • BROOKLYN, N. Y. 11217 • 624-5531

RESPIRATORY DISEASE SCREENING REPORT

Date: 12-12-72 Height 5-6 Weight 168

Name: Last [redacted] First [redacted] Initial ____ Age 53 Sex Male

Address: 16 Lefferts Place BKLYN Zip Code 11238

Occupation: Present P.S. #8-5 Previous ____

Personal Physician: ____ Referred by: JOHN J. GRECO, M.D.

Address: ____ KENTILE FLOORS INC. 58 2nd AVE., BKLYN, N.Y. 11215

X-RAY FINDINGS: No pathological findings

PULMONARY FUNCTION TEST FINDINGS: V.C. = 2300 cc = moderate restrictive pattern

QUESTIONNAIRE

SYMPTOMS:

Do you cough every day? nO What time of day? ____ A.M. ____ P.M.

Have you recently had a cough that lasted 3 weeks or more? nO

During the past two years, have you had a cough lasting 3 months or more? nO

Have you ever coughed up blood? nO How much? ____ When? ____

Do you cough up phlegm? nO

How much in 24 hours? 1 tbsp. ____ 2 tbsp. ____ More ____ Less ____

Color: White ____ Yellow ____ Green ____

Are you usually short of breath? NO

Are you short of breath after exercise or exertion? NO

Can you walk up two flights of stairs without shortness of breath? Yes

Do you have a whistle or wheezing in your chest? NO

ILLNESSES:

In the past have you ever had:

Heart trouble? nO

A chest disease? NO What kind? ____

A chest operation? NO What kind? ____

Has a physician told you that you have:

Bronchitis? NO Hay Fever? nO Other chest disease? ____

Emphysema? nO Pleurisy? nO Specify ____

Asthma? nO Tuberculosis? NO

SP424637

SMOKING HISTORY:

Do you smoke? Yes What? CIG.

If cigarettes, how much: Less than 20 cigarettes a day? 20 How many packs? ____ SH WLK.

Have you ever smoked? ____

[illegible] smoking? 16 ____ When did you stop? ____

BROOKLYN TUBERCULOSIS & RESPIRATORY DISEASE ASSOCIATION, INC.
293 SCHERMERHORN STREET, BROOKLYN, N. Y. 11217 (212) 624-8531

DATE: 12/21/72.

TO: Brooklyn Tuberculosis & Respiratory Disease Association

FROM: [redacted]hn J. Greco, M.D. Kentile Floors Inc.

RE: [redacted] AGE: 53 [redacted]ce

The test findings of the above named person indicate a need for further study.

Your cooperation in returning this report will aid us in evaluating our work and enable us to give you better service.

REPORT

The above named patient has been examined by me and the following diagnosis is my impression.

_____ Negative for tuberculosis

_____ Tuberculosis - active

_____ Tuberculosis - activity undetermined

_____ Tuberculosis - inactive - receiving treatment

_____ Tuberculosis - inactive - not receiving treatment

_____ Chronic Bronchitis

_____ Emphysema

_____ Pulmonary Fibrosis

_____ Malignancy

_____ Cardiac Abnormalities

_____ Other abnormal conditions (please specify)

Signed: _____

Additional information may be reported on the reverse side.

Group

LOST TIME

KENTILE, INC.

Brooklyn Plant

FOREMAN

NURSE'S REPORT ~~OF INJURY TO EMPLOYEE~~

Date of Report: 7-8-64 Time: 11:45 a.m.

Date of Injury: 7-8-64 Time: 11:30 a.m.

Name: [redacted] Dept.: Production

Address: [redacted] Occupation: Relief Man

Age: 43 Supervisor: D. Mangino (7-8-64)

S (M) W D How Long Employed: 1957 7½ yrs.

Patient's Story of How Injury Occurred: Employee states that he is coughing up some blood. Noticed first time this morning. Man gives no history of accident or injury upon questioning.

Nature of Injury: As above along with comment that blood was bright red in color; not dark. Working on air hammer (dusty). Temperature taken: (97.8). Pulse: 84 strong & regular. Sputum requested; patient unable to provide.

Disposition: To see own MD. Requested doctor note.

X-Ray: This has been ordered by own MD. Pt. will advise us.

Re-visits: 7-10-64: Patient brought doctor note not to return to work. Dr. has ordered X-ray. Patient appears apprehensive; says that he has not coughed up any more blood since Wednesday, 7-8-64. Dr. requested sputum sample - patient unable to provide.

D. Martin in Personnel to send man DB450 form.

C-2 no vjg C-14

C-104 C-14

C-4 C-11

SP424639

JOSEPH N. SAVINO, M. D., P.C.
168 CLINTON STREET
BROOKLYN, NEW YORK 11201
875-7744

August 19, 1976

Re: [redacted]
Injury Date: 8/18/76
Employer: Kentile Floors
W/C058930

Dear Dr. Quraishi:

RADIOGRAPHIC EXAMINATION: CHEST PA AND LATERAL:

There is no evidence of acute, recent or progressive pulmonary pathology.

The cardiac, hilar and mediastinal shadows are normal for the patient's stated age and habitus.

The visualized osseous structures and soft tissue components of the thorax are intact.

IMPRESSION: Negative radiographic examination of the chest.

Sincerely,

Joseph N. Savino, M.D., P.C.

JNS/ fs
films to Kentile Floors

8/20/76

STATEMENT OF CLAIM
FOR
ACCIDENT AND SICKNESS WEEKLY BENEFITS

Metropolitan Life Insurance Company
Group Health Claims

3/10/84

TO BE COMPLETED BY THE EMPLOYEE
(Please answer all questions)

1. Your name *(Print)*... [redacted] ... Phone (212)851-1209 (Include Area Code)

2. Present address: No. [redacted] ... State. [redacted]

☑ Male ☐ Female Date of birth 10/16/20 ☐ Single ☑ Married Social Security No. [redacted]

3. Date you were first disabled by this sickness or injury... ..... 19.....

4. If you were hospitalized, *as a bed patient*, please answer the following:

(a) Name and address of hospital Fort Hamilton Veterans Admin. Hospital, Fort Hamilton, NY

(b) Date admitted February 10, 1984 at 3:30 a.m. (p.m.)

(c) Date discharged ... 19 ... at ... a.m. p.m.

5. Was an accident involved ☐ Yes ☐ No If yes, please answer the following:

(a) When did the accident happen? Date.....19.....at... (Hour) a.m. p.m.

(b) Where did the accident happen? City. ..... State.....

(c) Where you at work when the accident happened? ☐ Yes ☐ No

(d) Give a brief description of the accident. .....

I authorize the Physician to release any information requested with respect to this Claim.
I certify that the information I furnished to support this claim is true and correct. I KNOW IT IS A CRIME TO FILL OUT THIS FORM WITH FACTS I KNOW ARE FALSE OR TO LEAVE OUT FACTS I KNOW ARE IMPORTANT.

Date. 3/14/ ..19 84 Signed *(Insured Employee)* [redacted]

TO BE COMPLETED BY THE EMPLOYER
(Please answer all questions)

1. Employee's name..... Employee's Identification No.

2. Amount of weekly benefit, $ ..... Effective date of employee's insurance 19

3. If this coverage has been canceled, give the date and reason .....

4. (a) Date last worked ..... 19 . (b) Date returned to work 19

5. If salary continued, give date salary paid through 19

6. Is the employee claiming or receiving workers' compensation benefits? ☐ Yes ☐ No

If Yes, what is the present status of the compensation claim? .....

7. Give any information which might assist Metropolitan Life in the consideration of this claim .....

KENTILE FLOORS INC.
BROOKLYN, N.Y.

26198 XX 001 0
☐ (01) (LOCAL 402) IAMAW
☐ (03) (LOCAL 457) URW
☐ (05) (LOCAL 3) IBEW
☐ (07) SALARIED
☐ (08) CHICAGO-ATLANTA
☐ (10) (LOCAL 505) URW

Date ..... 19 By ..... (Name) ..... (Title)

Telephone number ..... (Include Area Code)

SP424564

Form Approved
OMB No. 76-R0138

REQUEST FOR AND CONSENT TO RELEASE OF INFORMATION FROM CLAIMANT'S RECORDS

NOTE: 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, United States Code, and will authorize release of the information you specify. The information may also be disclosed outside the VA as permitted by law or as stated in the "Notices of Systems of VA Records" published in the Federal Register in accordance with the Privacy Act of 1974. Disclosure is voluntary. However, if the information is not furnished, we may not be able to comply with your request.

TO: Veterans Administration
MEDICAL CENTER
800 Poly Place
Brooklyn, N.Y. 11209

NAME OF VETERAN (Type or print): [redacted]

VA FILE NO. (Include prefix):

SOCIAL SECURITY NO.: [redacted] SS#

NAME AND ADDRESS OF ORGANIZATION, AGENCY, OR INDIVIDUAL TO WHOM INFORMATION IS TO BE RELEASED

TO: Kentile Floors Inc
58 Second Fine
Brooklyn N.Y. 11215

VETERAN'S REQUEST

I hereby request and authorize the Veterans Administration to release the following information, from the records identified above to the organization, agency, or individual named hereon:

INFORMATION REQUESTED (Number each item requested and give the dates or approximate dates—period from and to—covered by each.)

WARD: 12W WARD PHYSICIAN: Dr. Williams

1. DIAGNOSIS:
Cerebral Bleed

2. OPERATIONS OR OTHER PROCEDURES: (DATES)

3. RETURN TO WORK STATUS:

4. REMARKS:
RETURN TO CLINIC-DATE: _____
X PATIENT PRESENTLY HOSPITALIZED

5. CONVALESCENT PERIOD

PURPOSES FOR WHICH THE INFORMATION IS TO BE USED

PURPOSE OF INFORMATION: for disability Benefits

NOTE: Additional items of information desired may be listed on the reverse hereof.

DATE: 3/13/84

SIGNATURE AND ADDRESS OF CLAIMANT, OR FIDUCIARY, IF CLAIMANT IS INCOMPETENT

X [redacted]

FORM EC 1975 60-3288

EXISTING STOCKS OF VA FORM 07-3288, FEB 1974, WILL BE USED.

SP424565

HERBERT WIENER, M.D., P.C.
155 SMITH STREET
BROOKLYN, N. Y. 11201

ULSTER 5-3552
ULSTER 5-3512

DISABILITY CERTIFICATE

DATE 2/2/84

TO WHOM IT MAY CONCERN:

I HEREBY CERTIFY THAT [redacted]

HAS BEEN UNDER MY PROFESSIONAL CARE, AND WAS:

- ☐ TOTALLY INCAPACITATED
- ☐ PARTIALLY INCAPACITATED

FROM 2-1-84 TO: 2/6/84

REMARKS: G-I hemorrhage

SIGNED [signature]

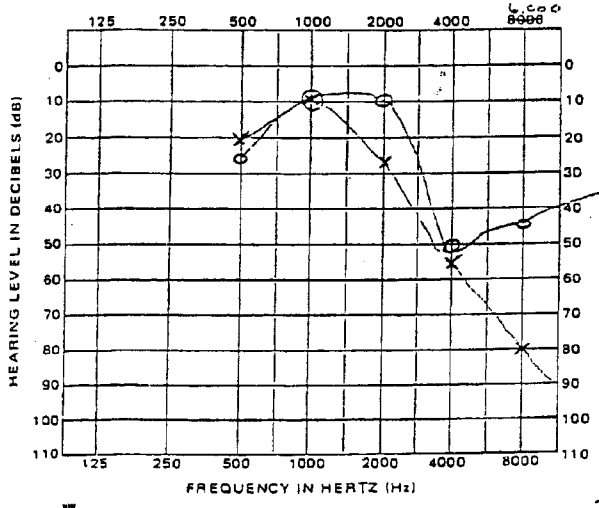
137-P

Returned to work on 2-6-84.

Was out on 2-2-84, 2-3-84 and 2-4-84 & 2-1-84

H. Wiener

NAME Nixon Brock DATE MH BY 7-11-83



AUDIOGRAM KEY

	Right	Left
AC Unmasked	O	X
AC Masked	△	□
BC Mastoid Unmasked	<	>
BC Mastoid Masked	□	□
BC Forehead Masked	⊤	⊤

Both	
BC Forehead Unmasked	↓
Sound Field	$

	Left Ear	Right Ear
S.R.T.		
M.C.L.		
T.D.		

NORTHEASTERN INSTRUMENTATION
6370 A 78th St., Middle Village, New York 11379
(212) 894-5875
Audiometer Sales & Service

INDUSTRIAL HEALTH, INC. 590542

COMPANY	PLANT LOCATION (CITY, STATE)	PLANT CODE	JOB NO.
KENTILE FLOORS INC	BROOKLYN, NY	02850	13552

EMPLOYEE NAME (LAST, FIRST) PRINT OR TYPE	SOCIAL SECURITY NO.	YR. HIRED	DEPT. NO.	I.D. NO.
[redacted]	[redacted]	1957	PRODUCTION 3	479

HAVE YOU EVER USED FIREARMS OR SERVED IN THE ARMED FORCES? ☑ YES ☐ NO	DO YOU WEAR EAR PROTECTION ON THE JOB? ☑ YES ☐ NO	DO YOU HAVE RINGING IN YOUR EARS? ☐ YES ☑ NO	ANY PROBLEMS WITH DIZZINESS OR UNSTEADINESS? ☐ YES ☑ NO	YEAR OF BIRTH 1920

HAVE YOU EVER HAD MEDICAL TREATMENT FOR AN EAR PROBLEM? ☑ YES ☐ NO IF YES, EXPLAIN: ABCESS BOTH EARS IN MILITARY

DO YOU HAVE ANY EAR OR HEARING PROBLEM NOW? ☐ YES ☑ NO IF YES, EXPLAIN:

DO YOU HAVE ANY NOISY HOBBIES? ☐ YES ☑ NO IF YES, EXPLAIN:

IF YOUR NAME AND SOC. SEC. NO. WERE PREPRINTED, PLEASE CHECK FOR ERRORS AND MAKE CORRECTIONS.

EMPLOYEE SIGNATURE [redacted]

TEST DATE	6/23/82
TIME OF TEST	☐ AM ☒ PM 2:00
☐ GRASON-STADLER 1703 ☐ MAKE:	MODEL:
SERIAL NO.	209
TECHNICIAN SIGNATURE	C. Mitchell

☐ MEDICAL REFERRAL ☐ P.M.H. ☐ ADVISE RETEST ☐ INVALID RESPONSE

REVIEWERS SIGNATURE Thomas L. Walker M.A.

HEARING LEVELS — ANSI 1969

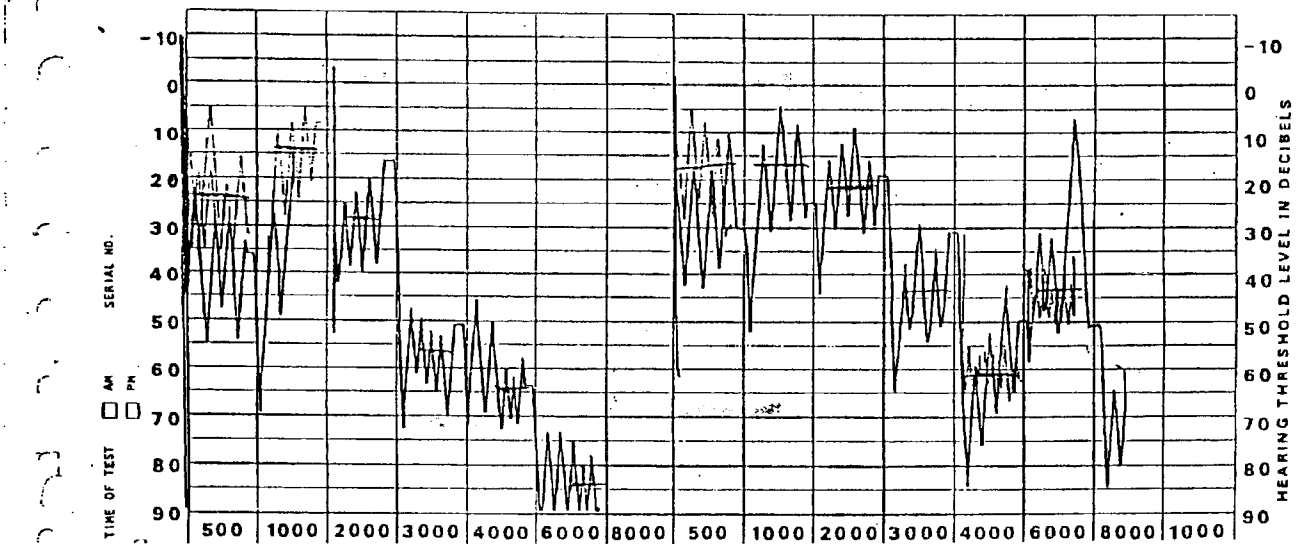
	500	1000	2000	3000	4000	6000	8000
LEFT EAR	25	15	20	55	65	85	X
RIGHT EAR	15	15	20	45	60	45	

DO NOT DETACH

DO NOT DETACH

© INDUSTRIAL HEALTH, INC. 1979

SP421568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HEARING THRESHOLD LEVEL IN DECIBELS
TIME OF TEST
AM
PM
SERIAL NO.

HERBERT WIENER, M.D., P.C.
155 SMITH STREET
BROOKLYN, N. Y. 11201

ULSTER 5-3532
ULSTER 5-3512

DISABILITY CERTIFICATE

DATE 1-22-81

TO WHOM IT MAY CONCERN:

I HEREBY CERTIFY THAT [redacted]

HAS BEEN UNDER MY PROFESSIONAL CARE, AND WAS:

☒ TOTALLY INCAPACITATED
☐ PARTIALLY INCAPACITATED

FROM 1-20-81 TO: 1-27-81

REMARKS: (1) bronchitis
(2) low back pain

SIGNED [signature]

137-P

Returned to work 1/27/81

STATE OF CALIFORNIA
AGRICULTURE AND SERVICES AGENCY
DEPARTMENT OF INDUSTRIAL RELATIONS

SEE REVERSE SIDE FOR INSTRUCTIONS

DIVISION OF INDUSTRIAL ACCIDENTS—WORKERS' COMPENSATION APPEALS BOARD

APPLICATION FOR ADJUDICATION OF CLAIM

CASE No.

Mr. [redacted] (INJURED EMPLOYEE) [redacted] (INJURED EMPLOYEE'S ADDRESS)

Social Security No. [redacted] January 2[redacted]

(APPLICANT, IF OTHER THAN INJURED EMPLOYEE) (APPLICANT'S ADDRESS AND ZIP CODE)

VS.

KENTILE FLOORS (EMPLOYER) 320-4566 (APPLICANT'S TELEPHONE NUMBER)

2929 California St. Torrance, (EMPLOYER'S ADDRESS)

AETNA INS. CO (EMPLOYER'S INSURANCE CARRIER OR STATE IF SELF-INSURED OR PERMISSIBLY UNINSURED) 3580 Wilshire Blvd. L. A. Calif. 90010 (ADDRESS OF INSURANCE CARRIER, IF ANY)

[illegible], Calif. 90[illegible]

IT IS CLAIMED THAT:

1. The injured employee, born 8/13/38 (DATE OF BIRTH) 1975, while employed as a Labor Pool (OCCUPATION AT TIME OF INJURY) on 1970-1975 (DATE OF INJURY) at Torrance, (CITY) California (STATE), by the employer sustained injury arising out of and in the course of employment to lungs, pulmonary system (STATE WHAT PARTS OF BODY WERE INJURED)

2. The injury occurred as follows: exposure to asbestos (EXPLAIN WHAT EMPLOYEE WAS DOING AT TIME OF INJURY AND HOW INJURY WAS RECEIVED)

3. Actual earnings at time of injury were: $3.93 per hour/ $50 hours per week (GIVE WEEKLY OR MONTHLY SALARY OR HOURLY RATE AND NUMBER OF HOURS WORKED PER WEEK)

(SEPARATELY STATE VALUE PER WEEK OR MONTH OF TIPS, MEALS, LODGING OR OTHER ADVANTAGES REGULARLY RECEIVED)

4. The injury caused disability as follows: (SPECIFY LAST DAY OFF WORK DUE TO THIS INJURY AND BEGINNING AND ENDING DATES OF ALL PERIODS OFF DUE TO THIS INJURY)

5. Compensation was paid ___ (YES) x (NO) $___ (TOTAL PAID) $___ (WEEKLY RATE) ___ (DATE OF LAST PAYMENT)

6. Medical treatment was received ___ (YES) x (NO) ___ (DATE OF LAST TREATMENT) All treatment was furnished by the employer or insurance company ___ (YES) x (NO) other treatment was provided or paid for by ___ (NAME PERSON OR AGENCY PROVIDING OR PAYING FOR MEDICAL CARE)

Doctors not provided or paid for by employer or insurance company, who treated or examined for this injury are

(STATE NAMES AND ADDRESSES OF SUCH DOCTORS AND NAMES OF HOSPITALS TO WHICH SUCH DOCTORS ADMITTED INJURED)

7. Unemployment Insurance or Unemployment Compensation Disability benefits have been received since the date of injury ___ (YES) x (NO)

SP255845

8. Other cases have been filed for industrial injuries by this employee as follows: (SPECIFY CASE NUMBER AND CITY WHERE FILED)

9. This application is filed because of a disagreement regarding liability for: Temporary disability indemnity___ Permanent disability indemnity x Reimbursement for medical expense x Medical treatment x Compensation at proper rate x Other___ Specify: ___ and applicant requests a hearing and award of the same, and for all other appropriate benefits provided by law.

Dated at Long Beach (CITY), California, 1/24/79 (DATE)

FELISA R. NAYFACK (APPLICANT'S ATTORNEY)
3888 Cherry Ave. Long Beach, Calif. 90807

PABLO ERNEST CARUL (APPLICANT'S SIGNATURE)

Please file signed original and six copies.

PULMONARY MEDICINE
INTERNAL MEDICINE

IRA A. GOULD, M. D.
322 EAST 19TH STREET, SUITE 3 A
NEW YORK, NEW YORK 10003
212 - 228-0470

October 17th, 1986

Johnson, Tannen et al
Counselors at Law
225 Broadway
New York, NY 10007

ATTN: Joel B. Rubin, Esq.

RE: [redacted]
DOB: 8/19/20
Emp: Kentile Floor, Inc.
58 Second Avenue
Brooklyn, NY 11215
Carrier: ?
C.C.# ?
WCB# ?
DOA: To be established.
[redacted]
Date of examination: 4/7/86

Gentlemen:

Thank you very much for asking me to report in the case of Mr. [redacted]

[redacted] was referred to me by his physician, Dr. Paolo DiStefano, for a pulmonary evaluation.

SYMPTOMS (related to present illness, in patient's own words):

1) Shortness of breath;
2) Chest pains when coughing;
3) Pain in upper back;
4) Difficulty breathing.

(continued)

SIGNIFICANT MEDICAL AND OCCUPATIONAL HISTORY

[redacted] worked for Kentile Floor, Inc. for approximately 30 years as a welder and burner. During the first 17 years of his employment at Kentile, he worked in a warehouse in which asbestos bags were stored, opened, and closed, causing him to be routinely exposed to quantities of asbestos dust; asbestos tiles were also stored in this warehouse, likewise emitting asbestos dust. The patient's duties since that time have also entailed abrading copper, welding aluminum and cast iron, and burning pipes and steel. These activities produced clouds of dust, smoke and various fumes to which the patient was continuously exposed during the course of his everyday employment. He was also exposed to the asbestos dust produced by asbestos tile processing and cleaning of machinery in his immediate working environment. The patient states that protective equipment was not worn and that there were no windows or ventilation system in his working environment.

On 6/25/85, Mr. [redacted] began experience the onset of a dry cough. He was seen by the company doctor on that date and was then referred to his private physician, Dr. Joseph Florio. Dr. Florio prescribed antibiotics and ordered chest X-rays. The patient improved slightly and remained stable until 3/5/86, when he started coughing violently and vomiting blood. The patient was hospitalized at Victory Memorial Hospital on 3/12/86, where he had a bronchoscopy on 3/27/86 and was diagnosed with chronic bronchitis and possible asbestosis.

[redacted] was forced to permanently discontinue his employment since 3/5/86 due to the persistence of the above-described symptoms.

Medications (related to present illness):
1) Theodur--300 mg; 1 every 8 hours;
2) Alupent--10 mg; 1 every 8 hours;

Smoking History: The patient has never smoked.

Presently Working: No Last Day of Work: 3/5/86

(continued)

OTHER MEDICAL HISTORY

Marital Status: Married

Number of Children: 2

Alcohol Usage: None

Other Hospitalizations: 1) Victory Memorial Hospital--8 years ago; Removal of fatty tissue on left side
2) Traumatic amputation of part of the right fourth finger

Other Symptoms: Ringing in right ear

Other Medical Conditions: None known

Allergies: None known

Other Medications: None

Family Medical History: Mother--Deceased; Pneumonia
Father--Deceased; Stroke
(ages unknown)

SIGNIFICANT PHYSICAL FINDINGS

Age: 65
Sex: Male
Color: White

Height: 68 inches
Weight: 210 1/2 pounds
Blood pressure: 140/76 mmHg
Temperature: 99.0 degrees F

Appeared short of breath on minimal exertion.
Bibasilar dry rales heard on auscultation of the lungs.
Absent middle and distal phalanges of 4th finger of right hand.
Borderline digital clubbing.

(continued)

SIGNIFICANT LABORATORY FINDINGS

WBC: 8,400/cubic mm
Grans: 53%
Lymphs/monos: 47%
Platelets: 252,000/cubic mm
HCT: 54%
Urinalysis: Within Normal Limits
pH: 6.0
Specific gravity: 1.020

Electrocardiogram: Normal Sinus Rhythm. Left Electrical Axis. Small Q waves in I and AVL.

Chest Roentgenograms taken in the standard postero-anterior and left lateral projections: Multiple bilateral pleural plaques. Coarse linear densities in moderate profusion in both lower lung fields. Loss of lung volume bilaterally. Borderline heart size.

PULMONARY FUNCTION STUDIES

* Before bronchodilator
** After bronchodilator

	Observed			Predicted	% of Predicted		
	*	*	**		*	*	**
Peak Flow (L/sec)	9.0	8.6	10.2	8.5	106	101	120
Forced Vital Capacity (L)	2.6	2.4	3.1	4.0	65	60	78
FEV 0.5 sec (%)	69	70	64				
FEV 1 sec (%)	86	88	81				
FEV 3 sec (%)	100	100	96				
FEV 0.5 sec (L)	1.8	1.7	2.0	2.1	86	81	95
FEV 1 sec (L)	2.2	2.1	2.4	3.0	73	70	80
FEV 3 sec (L)	2.6	2.4	2.9	3.8	68	63	76
MVV (L/min)	40	55	104	128	31	43	81

(continued)

PULMONARY FUNCTION STUDIES (continued)

Interpretation: Moderate reduction of Forced Vital Capacity. Moderate reduction of Maximum Voluntary Ventilation. Slight airflow obstruction. Some improvement in all tests after bronchodilator administration.

CONCLUSIONS

In view of the above, I have the following opinions with a reasonable degree of medical certainty:

Diagnoses:

1) Pulmonary Asbestosis;
2) Pleural Asbestos-related Disease;
3) Chronic Irritative Bronchitis;
4) Chronic Obstructive Airway Disease.

Pulmonary Functional Impairment: Moderate, Partially-reversible Pulmonary Restriction. Minimal, Partially-reversible Airway Obstruction. Moderate, Partially-reversible Reduction of Exertional Ventilation.

Causal Occupational Relationship: There is a clear causal relationship between the patient's occupational exposures and his development of Diagnoses #1, 2, 3 and 4.

Degree of Occupationally-related Disability: Total and Permanent.

Prognosis: Poor. The patient's pulmonary conditions are expected to worsen with time. In addition, the patient is at increased risk of developing a malignancy.

There is a need for continuing medical care, and authorization for this should be requested.

(continued)

Recommendations for Therapy:

1) Avoidance of all pulmonary-offending agents;
2) Should not return to his usual occupation;
3) Avoidance of crowded conditions such as public transportation;
4) Avoidance of inclement weather and extremes of temperature and humidity;
5) Pneumococcal and influenza vaccines;
6) High fluid intake and expectorant;
7) Continue present medications;
8) Periodic medical examination and chest X-rays;
9) Periodic sputum cytology studies;
10) Home oxygen therapy might be indicated in the future;
11) Prompt treatment of any respiratory infections.

Thank you very much once again for asking me to report on Mr. Catuogno. If I can be of any further assistance to you, please do not hesitate to call upon me. I am available for testimony on the first and fourth Tuesday afternoons of each month at the Workers' Compensation Board in Brooklyn, N.Y. only.

In keeping with Part 22 of the New York State Sanitary Code (August 1, 1982), I have sent a copy of this report to: Division of Health Risk Control, New York State Department of Health.

Sincerely yours,

Ira A. Gould, M.D.

Ira A. Gould, M.D.
WCB Authorization #094552-7
WCB Rating Code: CIM-PD

cc: Employer: Kentile Floor, Inc.
Paolo DiStefano, M.D.
Workers' Compensation Board
New York State Dept. of Health
IAG/jae

STATE OF CALIFORNIA
AGRICULTURE AND SERVICES AGENCY
DEPARTMENT OF INDUSTRIAL RELATIONS

SEE REVERSE SIDE FOR INSTRUCTIONS

DIVISION OF INDUSTRIAL ACCIDENTS—WORKERS' COMPENSATION APPEALS BOARD

APPLICATION FOR ADJUDICATION OF CLAIM CASE No.

Mr. M[redacted] (INJURED EMPLOYEE)

[redacted] (INJURED EMPLOYEE'S ADDRESS)

Social Security No. 264[redacted]

T[redacted] Calif 90[redacted]

January 20, 1979

(APPLICANT, IF OTHER THAN INJURED EMPLOYEE)

(APPLICANT'S ADDRESS AND ZIP CODE)

vs.

1. Kentile Floors
2. FLINT KOTE

1. 2929 California Torrance, Calif
2. 550 S. Alameda, Vernon, Calif

(EMPLOYER'S ADDRESS)

320-8298

(APPLICANT'S TELEPHONE NUMBER)

1. Aetna Ins Co
2. Liberty Mutual Ins Co.

(EMPLOYER'S INSURANCE CARRIER OR STATE IF SELF-INSURED OR PERMISSIBLY UNINSURED)

3580 Wilshire Blvd. Los Angeles, CA
6006 Wilshire Blvd. L.A., CA 90036

(ADDRESS OF INSURANCE CARRIER, IF ANY)

IT IS CLAIMED THAT:

1. The injured employee, born 8/13/34, while employed as a maintenance mechanic
(DATE OF BIRTH) (OCCUPATION AT TIME OF INJURY)
on 1976 - present (DATE OF INJURY) at Vernon (CITY), California (STATE), by the employer sustained injury arising out of and in the course of employment to lungs, pulmonary system
(STATE WHAT PARTS OF BODY WERE INJURED)

2. The injury occurred as follows: exposure to asbestos
(EXPLAIN WHAT EMPLOYEE WAS DOING AT TIME OF INJURY AND HOW INJURY WAS RECEIVED)

3. Actual earnings at time of injury were: $4.90 per hour/ 50 hours per work
(GIVE WEEKLY OR MONTHLY SALARY OR HOURLY RATE AND NUMBER OF HOURS WORKED PER WEEK)
(SEPARATELY STATE VALUE PER WEEK OR MONTH OF TIPS, MEALS, LODGING OR OTHER ADVANTAGES REGULARLY RECEIVED)

4. The injury caused disability as follows:
(SPECIFY LAST DAY OFF WORK DUE TO THIS INJURY AND BEGINNING AND ENDING DATES OF ALL PERIODS OFF DUE TO THIS INJURY)

5. Compensation was paid ___ (YES) x (NO) $ (TOTAL PAID) (WEEKLY RATE) (DATE OF LAST PAYMENT)

6. Medical treatment was received ___ (YES) x (NO) (DATE OF LAST TREATMENT) All treatment was furnished by the employer or insurance company ___ (YES) x (NO) other treatment was provided or paid for by
(NAME PERSON OR AGENCY PROVIDING OR PAYING FOR MEDICAL CARE)
Doctors not provided or paid for by employer or insurance company, who treated or examined for this injury are
(STATE NAMES AND ADDRESSES OF SUCH DOCTORS AND NAMES OF HOSPITALS TO WHICH SUCH DOCTORS ADMITTED INJURED)

7. Unemployment Insurance or Unemployment Compensation Disability benefits have been received since the date of injury. ___ (YES) xx (NO)

SP255843

8. Other cases have been filed for industrial injuries by this employee as follows:
(SPECIFY CASE NUMBER AND CITY WHERE FILED)

9. This application is filed because of a disagreement regarding liability for: Temporary disability indemnity x Permanent disability indemnity x Reimbursement for medical expense x Medical treatment x Compensation at proper rate x Other ___ Specify:
and applicant requests a hearing and award of the same, and for all other appropriate benefits provided by law.

Dated at Long Beach (CITY), California, 1/24/79 (DATE)

FELISA R. NAYFACK (APPLICANT'S ATTORNEY)
3888 Cherry Ave. Long Beach, Calif. 90807
(ADDRESS AND TELEPHONE NUMBER OF ATTORNEY)

ORTENIO RUIZ (APPLICANT'S SIGNATURE)

Please file signed original and six copies

LAW OFFICES
STEVEN ROSEMAN
ATTORNEYS AND COUNSELORS AT LAW

1625 WEST OLYMPIC BOULEVARD • SUITE 803
LOS ANGELES CALIFORNIA 90015
PHONE (213) 381-3811 • 385-1071

3888 CHERRY AVENUE
LONG BEACH CALIFORNIA 90807
PHONE (213) 595-6021

STEVEN ROSEMAN
ANTHONY J. BRADISSE
ROBERT T. CROFOOT
ROBERT E. BAKER
EDWARD A. VILLALOBOS
EDWARD S. ORCHON
FELISA R. NAYFACK
ANDREW H. NASH
STEVEN M. BARRY
JOHN M. SHERMAN

ALFRED BORNSTEIN
OF COUNSEL

JERROLD S. FREED
OF COUNSEL

January 26, 1979

Workers' Compensation Appeals Board
6450 Garfield Ave
Bell Gardens, Calif 90210

Re: [redacted] vs FLINT-KOTE & KENTILE FLOORS
Liberty Mutual & Aetna Ins
Date/ Inj: 1976 - present

Gentlemen:

Enclosed please find original and six copies of application filed on behalf of the above named applicant.

By copy of this letter, we are this day serving a copy of the application on the employer and/or the insurance carrier(s) named above. In accordance with the Rules of Practice and Procedure, request is made that said named parties serve their entire medical file upon this office within ten(10) days of the date of this letter.

Demand is made that this office be served with copies of any statements taken of this applicant.

PLEASE RETAIN THIS CASE OFF CALENDAR TO ALLOW APPLICANT'S COUNSEL AN OPPORTUNITY TO INVESTIGATE THE CASE AND REVIEW MEDICAL REPORTS.

Thank you.

SP255842

Very truly yours,

LAW OFFICES OF STEVEN ROSEMAN

BY _____
FELISA R. NAYFACK

FRN/ra

enc:

cc: LIBERTY MUTUAL INS.
6006 Wilshire Blvd.
Los Angeles, Ca. 90036

AETNA INS CO
3850 Wilshire Blvd.
Los Angeles, Calif. 90010

JAN 29 1979
CLAIMS

STATE OF ILLINOIS
INDUSTRIAL COMMISSION
160 NORTH LA SALLE STREET
CHICAGO, ILLINOIS 60601

☐ AMENDED

APPLICATION FOR ADJUSTMENT OF CLAIM

(File four copies of this form)

NOV 21 | 48 PM 83

ILLINOIS INDUSTRIAL COMMISSION

1. Workers' Compensation ☐ OR 2. ☒ 3.
4. Non-Fatal ☒ OR Fatal ☐ 5.

/6. [redacted]
EMPLOYEE - PETITIONER (1AA)

/7. Case Number: 83 OD 768 (OFFICE USE ONLY)

/8. KENTILE FLOORS, INC.
EMPLOYER - RESPONDENT (3AA)

/9. (OFFICE USE ONLY)

The Petitioner alleges the following particulars relative to this Application under the provisions of the Workers' Compensation or Occupational Diseases Act:

/10. EMPLOYER'S NAME (3A-1)	/11. ADDRESS	/12. CITY	/13. ZIP CODE
Kentile Floors, Inc.	4532 S. Kolin	Chicago, IL	60632

/14. INJURED EMPLOYEE'S NAME (1AA/8AA)	ADDRESS	CITY	ZIP CODE
[redacted]			

DEPENDENTS

NAME	AGE	RELATIONSHIP
1.		
2.		
3.		
4.		

(Attach separate sheet for more than four)

Is Petitioner currently receiving Temporary Total Disability Benefits in the proper amount?
☐ Yes ☒ No ..... If no,
Has Petitioner Returned to Work?
☒ Yes ☐ No .....

Location of Accident or Last Exposure /18. Chicago, Illinois (City, State)
Phone Number /19.
Social Security # /20. [redacted]
Sex /21. Male
Marital Status /22. Single
Total # Dependents /23. 0
Birthdate /24. 11 (Month) - 2 (Day) - 29 (Year)
Gross Weekly Wage (Excludes Overtime) /25. $ In excess of: 350.00
Date of Accident, Last Exposure, Disability or Death /26. On or about 5 (Month) - 2 (Day) - 81 (Year)
Is Petition for Immediate Hearing Attached? /27 ☐ Yes ☒ No
Actual or Anticipated Return to Work Date /28. - (Month) - (Day) - (Year)

Commission Use Only

How did Accident or Illness occur (Type)? Injured at work /29.
Part of Body Affected? Body - Lungs /30.
Nature of the Injury? /31.

Has a prior Application been filed with the Industrial Commission by Petitioner or on Petitioner's Behalf?
☒ Yes ☐ No
If yes, give number and disposition, if any: 83 OD 768

How did Employer get Notice of Accident? /32. ☒ Orally ☐ Written
Was Employee given Industrial Commission Information Handbook? /33. ☒ Yes ☐ No

NOTE TO THE PETITIONER: THIS IS A LEGAL DOCUMENT. BE SURE ALL THE ABOVE BLANKS ARE FILLED IN CORRECTLY AND THAT YOU HAVE READ AND UNDERSTOOD THE STATEMENTS BELOW BEFORE YOU SIGN.

DATE/34. November 18, 1983 (Month, Day, Year)
J C Smith [illegible] (Petitioner's Signature)

I hereby enter my appearance as Attorney for Petitioner and certify that I have not directly or indirectly solicited employment by the Petitioner, a know of no solicitation for said Petitioner by any person that has resulted in the employment of myself or any member of my firm. A copy of Attorn Representation Agreement is filed with this Application for Adjustment of Claim.

/35. THOMAS R. LICHTEN (ATTORNEY (2AA))
/38. Chicago, Illinois 60603 (CITY, STATE, ZIP CODE)
/36. Katz, Friedman, Schur & Eagle (FIRM NAME)
/39. [illegible] 11.11 (SIGNATURE)
/37. 7 S. Dearborn Street (ADDRESS)
/40. 263-6330 (TELEPHONE NO.)

IC 1(1-81) DISCLOSURE OF THIS INFORMATION TO THE INDUSTRIAL COMMISSION IS DONE VOLUNTARILY UNDER IL. REV. STAT. CH. 48 138.8. APPROVED BY FORMS MANAGEMENT.

SP051696

STATE OF ILLINOIS
INDUSTRIAL COMMISSION
160 NORTH LA SALLE STREET
CHICAGO, ILLINOIS 60601

AMENDED

APPLICATION FOR ADJUSTMENT OF CLAIM

(File four copies of this form)

FILED
Nov 21 1 48 PM '83
ILLINOIS INDUSTRIAL COMMISSION

1. Workers' Compensation: /☒ OR 2. Occupational Disease: /☐ OR 3. Non-Fatal /☒ OR 4. Fatal /☐

/6. [redacted]
EMPLOYEE - PETITIONER (1AA)

-vs-

/8. KENTILE FLOORS, INC.
EMPLOYER - RESPONDENT (3AA)

/7. Case Number: 83 WC 039415 (OFFICE USE ONLY)

/9. (OFFICE USE ONLY)

The Petitioner alleges the following particulars relative to this Application under the provisions of the Workers' Compensation or Occupational Disease Act:

/10. EMPLOYER'S NAME (3AA)	/11. ADDRESS	/12. CITY	/13. ZIP CODE
Kentile Floors, Inc.	4532 S. Kolin	Chicgao, IL	60632

INJURED EMPLOYEE'S NAME (1AA/5AA)	ADDRESS	CITY	ZIP CODE
[redacted]			

DEPENDENTS

NAME	AGE	RELATIONSHIP
1.		
2.		
3.		
4.		

(Attach separate sheet for more than four)

Is Petitioner currently receiving Temporary Total Disability Benefits in the proper amount?

☐Yes ☒ No .....If no,

Has Petitioner Returned to Work?

☒ Yes ☐ No .....

/18. Location of Accident or Last Exposure: Chicago, Illinois (City / State)

/19. Phone Number:

/20. Social Security #: [redacted]

/21. Sex: Male

/22. Marital Status: Single

/23. Total # Dependents: 0

/24. Birthdate: 11 - 2 - 29 (Month / Day / Year)

/25. Gross Weekly Wage (Exclude Overtime): In excess of: $ 350.00

/26. Date of Accident, Last Exposure, Disability or Death: On or about 4 - 30 - 81 (Month / Day / Year)

/27 Is Petition for Immediate Hearing Attached? ☐ Yes ☒ No

/28. Actual or Anticipated Return to Work Date: - - (Month / Day / Year)

Commission Use Only

How did Accident or Illness occur (Type)? Injured at work /29.

Part of Body Affected? Body /30.

Nature of the Injury? /31.

Has a prior Application been filed with the Industrial Commission by Petitioner or on Petitioner's behalf?

☒Yes ☐ No

If yes, give number and disposition, if any: 83 WC 39415

/32. How did Employer get Notice of Accident? ☒ Orally ☐ Written

/33. Was Employee given Industrial Commission Information Handbook? ☒ Yes ☐ No

NOTE TO THE PETITIONER: THIS IS A LEGAL DOCUMENT. BE SURE ALL THE ABOVE BLANKS ARE FILLED IN CORRECTLY AND THAT YOU HAVE READ AND UNDERSTOOD THE STATEMENTS BELOW BEFORE YOU SIGN.

/34. DATE: November 18, 1983 (Month / Day / Year)

Petitioner's Signature: J. C. Smith / K.S.S.

I hereby enter my appearance as attorney for Petitioner and certify that I have not directly or indirectly solicited employment by the Petitioner, know of no solicitation of said Petitioner by any person that has resulted in the employment of myself or any member of my firm. A copy of Attorney Representation Agreement is filed with this Application for Adjustment of Claim.

/35. ATTORNEY (2AA)	/36. CITY	STATE	ZIP CODE
THOMAS R. LICHTEN	Chicago,	Illinois	60603

/35. FIRM NAME: Katz, Friedman, Schur & Eagle

/39. SIGNATURE: Thomas R. Lichten

/37. ADDRESS: 7 S. Dearborn Street

/40. TELEPHONE NO.: 263-6330

I.C.1 (9-81)

DISCLOSURE OF THIS INFORMATION TO THE INDUSTRIAL COMMISSION IS DONE VOLUNTARILY UNDER IL. REV. STAT. CH. 48.138.6. APPROVED BY FORMS MANAGEMENT.

SP051697

WORKERS' COMPENSATION APPEALS BOARD
DIVISION OF INDUSTRIAL ACCIDENTS
DEPARTMENT OF INDUSTRIAL RELATIONS
STATE OF CALIFORNIA

RECEIVED
JUL 29 1992
LAW OFFICES OF
BILL PARRISH

COMPROMISE AND RELEASE (Dependency Claim) (Partial)

CASE NO. SFO 356286

(Mr.)
x(Mrs.)
(Miss) [redacted]
vs. APPLICANT

SOCIAL SECURITY NO.

ADDRESS

BETHLEHEM STEEL CORPORATION
CORRECT NAME OF EMPLOYER

c/o Associated Claims Management, Inc
P.O. BOX 9396, Walnut Creek, CA 94598
ADDRESS

SELF-INSURED
CORRECT NAME OF INSURANCE CARRIER

ADDRESS

The parties hereto, for the purpose of compromise only, agree as follows:

1. The above-named applicant claims that [redacted] while employed at
CORRECT NAME OF EMPLOYER
San Francisco, CA on 8/7/42 trough 1/30/42
by Bethlehem Steel Corporation, then insured as to workers' compensation liability
by Self-Insured
STATE NAME OF INSURER OR SELF-INSURER
sustained injury arising out of and in the course of such employment as follows: exposure to asbestos - mesothelioma

2. The death of said employee occurred on February 25, 19 91, as a result of the claimed injury.

3. The actual weekly wages of the employee at the time of claimed injury were in dispute, while average weekly wages (statutory) were minimum

4. Payments of compensation to the employee in his lifetime on account of the claimed injury were None

5. The applicant herein claim to have been dependent upon said employee at the time of claimed injury, and state the names, ages, relationship to and the extent of dependency upon said deceased employee to have been as follows:

NAME	AGE	RELATIONSHIP	EXTENT OF DEPENDENCY
[redacted]		wife	in dispute

RECEIVED
AUG - 7 1992
Division of Workers' Compensation
San Francisco

6. The parties hereby agree to settle any and all claims of said dependent on account of the claimed injury and the death of said employee by payment of the sum of $ 3,000.00, payable as follows to [redacted] less approved attorney fees.

SP452752

7. The parties hereby agree (if such items of expense be claimed) that medical, hospital and burial expense required by reason of the alleged injury and the death of the employee shall be borne as follows: not by defendant Bethlehem Steel Corporation

004

8. The name and address of applicant's attorney (if any): John C. Smith, Jr. 165 Fell Street

San Francisco, CA 94162

who requests a fee of $ 400.00, having been previously paid $ None

9. Reason for compromise See attached Reason for Compromise and Exhibit A

10. The undersigned request that this compromise agreement and release be approved.

11. Upon approval of this compromise agreement as provided by law, and payment in accordance with the provisions of said order of approval, said applicants and each of them do hereby release and forever discharge said employer and said insurance company of and from all claims, demands, actions or causes of action, of every kind or nature whatsoever, on account of, or by reason of the injury and death sustained as aforesaid by the employee, and in particular of any, all and every claim or cause of action which the undersigned, heirs, executors, representatives, or administrators may have had, now have, or shall hereafter have against said employer, said insurance carrier, and each of them under Division IV of Labor Code of the State of California.

12. It is agreed by all parties hereto that the filing of this document is the filing of an application on behalf of the applicant and that it may be set for hearing as a regular application, reserving to the parties the right to put in issue any of the facts admitted herein, and that if hearing is held with this document used as an application the defendants shall have available to them all defenses that were available as of the date of filing of this document, and that it may thereafter be approved, disapproved, or a decision issued after a hearing has been held and the matter regularly submitted.

13. For the purpose of determining the lien claim filed herein for the unemployment compensation disability and/or unemployment compensation benefits which have been paid under or pursuant to the California Unemployment Insurance Code, the parties propose the following division of the sum agreed upon for settlement and release of this case:

$ None for temporary disability covering the period _____ to _____

$ None for accrued medical expense paid or incurred by the employee.

$ None for future medical care.

$ None for permanent disability.

(The above segregation must be fair and reasonable and must be based on the real facts of the case. There should be no attempt made to deprive the lien claimant of a reasonable recovery consistent with all the amounts involved.)

Witness the signature hereof this 24th day of July 1922 at San Francisco, Cal.

[redacted]

Ruth Capell, Applicant

[redacted]

K. Alvarenga

Witness

John C. Smith, Jr. Atty. for Applicant

Bill Parrish

Bill Parrish, Atty. for Bethlehem Steel Corporation

THIS APPLICANT'S SIGNATURE MUST BE ATTESTED BY TWO DISINTERESTED WITNESSES OR ACKNOWLEDGED BEFORE A NOTARY PUBLIC.

STATE OF CALIFORNIA } ss.
County of _____

On this _____ day of _____ A.D. 19____, before me, _____ a Notary Public in and for the said County and State, residing therein, duly commissioned and sworn, personally appeared _____ known to me to be the person whose name _____ subscribed to the within Instrument, and acknowledged to me that he executed the same.

SP452753

IN WITNESS WHEREOF, I have hereunto set my hand and affixed my official seal the day and year in this Certificate first above written.

005

Notary Public in and for said County and State of California

REASON FOR COMPROMISE

APPLICANT'S NAME: Ruth Capell

WCAB NO: SFO 350286

The principle issues are injury arising out of and incurring in the course and scope of employment; Statute of Limitations; Jurisdiction of the Workers' Compensation Appeals Board; nature, extent, and duration of disability; liability for self-procured treatment; death as a result of the alleged injuries; apportionment.

The Applicant desires a lump sum certain and settlement. Defendant desires to buy peace and parties wish to avoid the hazards, delays, uncertainties and expense of further litigation. The parties expressly agree that the proposed settlement is meant to cover all aspects of the injury alleged herein as to Bethlehem Steel Corporation only.

I have been advised and fully understand that this Compromise and Release agreement releases any and all claims to death benefits relating to the injury or injuries covered by this Compromise agreement.

A serious and good faith issue exists over AOE/COE and Labor Code 5500.5 which, if decided against the Applicant, would defeat all her rights to benefits.

X [redacted]
APPLICANT, [redacted]

July 24, 1992
DATE

ATTORNEY FOR APPLICANT

7-24-92
DATE

SP452754

EXHIBIT "A"

APPLICANT'S NAME: Ruth Capell

WCAB NO.: SFO 350286

Applicant has been fully informed of her rights in this matter, including the following:

1. The right to have a full hearing before a Workers' Compensation Judge, to determine rate of disability and benefits, if any, if so ordered by the Workers' Compensation Judge.

2. That there is a possibility that upon hearing of all issues, Applicant may be awarded more or less than the amount in the Compromise and Release.

3. Applicant, by signing this agreement, fully realizes that defendant will not be responsible for any further expenses.

4. That Applicant understands that this Compromise and Release is a final settlement of her claim against Defendant. That upon approval by the Workers' Compensation Judge, she cannot file a further claim for asbestos and noxious fumes related injuries against said defendant.

Applicant by her signature below, acknowledges that she fully understands the above and freely waives the rights enumerated here.

X APPLICANT

SP452755

222 East 90th Place
Chicago, Illinois 60619
312/874-5746

September 20, 1974

State of Illinois Department of Labor
Ms. Harriet Pacini
Labor Standard - Labor Board
Room 1400
160 North La Salle Street
Chicago, Illinois 60601

Dear Ms. Pacini:

Enclosed please find for your inspection a copy of a letter from my former employer KENTILE FLOORS, INC., dated September 12, 1974, informing me that I have been terminated.

My name is Leon Stevens, social security number 352-18-4985. I have been an employee of Kentile Floors, Inc operating out of the Chicago Branch for twenty-four years and ten months, my date of hire was November 13, 1949. On August 28, 1974, at the doctor's instruction I entered Veterans Illinois Reserach Hospital for treatment to a small ulcer on my left ankle, I am still hospitalized. There is also still a question as to whether this ulcer developed as a result of being in direct contact with certain chemicals at Kentile.

I am writing to you in the hopes of obtaining help - a recourse of some kind with regards to my lost employment. I can not believe that after so many years of service an employee can be terminated with no more than a short note, and four weeks of severance pay (hardly sufficient) which I have not even received as yet. There was not even any mention of my profit sharing distribution.

I am more than willing and eager to take any steps that you feel are necessary, obtaining counsel or whatever - in order to secure my future which at the age of forty-nine, married with small children to support, seems quite bleak.

Thank you in advance for any and all help you can give me and I will await your reply.

Sincerely,

H-11-11-49 He
11-1-56 - Sal
OTerm - 8-20-74

LAST DAY WORKED AUG 20
CLAIM Sal CONT 20 WKS MAX VER
SEV PAY MAILED 9-20-74 TO S. TALLO

LEON STEVENS
LS:sl

cc: Mr. Loff - Kentile Floors, Inc!
Personnel Department - Brooklyn, N. Y.

S. E. Tallo, Sr. - Kentile Floors, Inc.
Plant Manager - Chicago, Illinois

10-19-71 - OV - ULCER LEFT ANK Sl
8-20-74 - LAB WORK Sl 6