FILE NAME: Contract Unit Workers Comp Claims (WCC)

DATE: 1959

DOC#: WCC027

DOCUMENT DESCRIPTION: Workers Comp File - Viall, Lloyd V

Contains all documents found in the Claimant's file, with one blank page between each separate document

Claimant	State
Lloyd U. Viall	Nevada

Initial Claim	Date
Armstrong Cont and Supply	8/10/59

NEVADA INDUSTRIAL COMMISSION CARSON CITY, NEVADA Form C-2 (Rev. 10-58)	REPORT OF INJURY OR OCCUPATIONAL DISEASE and WORKMAN'S CLAIM FOR BENEFITS	CLAIM NUMBER

FIRST REPORT OF ACCIDENT TO BE COMPLETED BY EMPLOYEE, PHYSICIAN AND EMPLOYER

THE NEVADA INDUSTRIAL COMMISSION REQUESTS THIS COMPLETED REPORT TO BE MAILED TO THE CARSON CITY OFFICE WITHIN FIVE (5) DAYS OF THE ACCIDENT. (IF INJURY OCCURRED IN NYE, LINCOLN OR CLARK COUNTY, SEND A COPY TO LAS VEGAS OFFICE.) Notification of accident—see Section 616.340 NRS. Penalty for non-compliance—see Section 616.650 NRS.

EMPLOYER—COMPLETE THE FOLLOWING:

EMPLOYER

Name on Certificate of Insurance: Armstrong Contracting & Supply Corp. prior to 1/1/58 Armstrong Cork Company — Policy Account Number: 10234

Mailing Address: 120 N. Lime Street, Lancaster, Pa. — Telephone Number:

Nature of Business: Erection of insulating materials — Under what classification have you been reporting employee?

EMPLOYEE

Name (Per Payroll) — Age: 40

Home Address: 5485 S. 4270 W., Kearns 18, Utah — Sex: M

Marital Status: M

Occupation and Usual Duties: Insulation Mechanic Traveler — Name state in which hired / Length of employment with you in Nevada: California — How Long Employed By You?: 96 days (Months)

ACCIDENT OR EXPOSURE TO DISEASE

Accident or Exposure Occurred — Place: Bethlehem Shipyard, San Francisco, Calif. Crown Zellerbach, Antioch, Calif. Stead A.F.B., Reno, Nevada; Beale A.F.B., Marysville, Calif — Hour AM PM — Date

Describe how Accident Occurred: No accident involved. Normal working conditions applying various insulating materials to metal surfaces at the above locations.

Did injured report accident or exposure at once? (Explain "No"): No accident. Working conditions normal. — ☒ No ☐ Yes

Did he report accident or exposure to his supervisor? (Give name): Advised voluntary quit to Mr. David H. Harper 5-20-59 — ☐ No ☒ Yes

Were there witnesses to accident or exposure? (Give names): Unknown — ☐ No ☐ Yes

Did accident or exposure to occupational disease occur while at regular work and on company time? (Explain "No"): Unknown — ☐ No ☐ Yes *

Was injured intoxicated or misconducting himself at time of accident? (Explain "Yes"): Unknown — ☐ Yes ☐ No

DISABILITY AND DEPENDENCY

Date disability commenced: Unknown — Last day wages were paid or will be paid: 5-15-59 — Date back on Job: Did not return *

If and when doctor says employee may do light work, will you have such work available? If workload requires — ☐ No ☐ Yes

Are you paying his wages during disability? No — ☐ Yes ☒ No *

Wages: Give average monthly wage regardless how paid: Established union wage rate per hour $3.975 — (Monthly) *

Is injured furnished room....., meals..... (number) or other advantages in addition to wages? (Explain): Established Union fringe expenses — ☐ No ☐ Yes

How many total dependents does injured claim for tax purposes? 7 *

I CERTIFY TO THE TRUTH OF THE FOREGOING STATEMENTS:

Date report completed: August 10, 19 59 — Signed by: [signature] — Title: District Manager

	FOR N.I.C. USE ONLY	RECEIVED
Policy No..... Class..... Policy Form..... Status Clerk..... Date 19	Checked by..... APPROVED BY: EXAMINER..... DATE.....	

Name	Birthdate	Age	Sex	Marital status

Address	Occupation at time of accident-exposure	Period employed this firm

Name of Employer	Date accident-exposure reported	Supervisor to whom reported

Accident or Last Known Exposure To Cause of Disease

Place of Accident — Hour AM PM — Date

Type and cause: Briefly describe the accident or exposure causing injury

Injury or Disease

Type of injury or disease	Body part(s) affected	Degree of Disability	
		No lost time ☐	Unable to work ☐
		Date last worked	Date returned to work

List persons residing in United States who are totally dependent on you for financial support.

Name	Relationship	Age	Name	Relationship	Age

I certify the above is a true statement in order to obtain the benefits of the Nevada Industrial Insurance and Occupational Diseases Acts.

Date — Place — Workman's Signature

PHYSICIAN—COMPLETE THE FOLLOWING:

The doctor may assist the injured workman to complete the above if necessary. Please see that he has signed his report. Notification by physician—see Section 616.345 NRS. Penalty for non-compliance—see Section 616.650 NRS.

First treatment: Place — Name of Hospital — Hour — Date

Diagnosis and description of injury or occupational disease:

Describe treatment used:

X-ray findings:

From information given you by employee, together with medical evidence, can you directly connect this accident or disease as job incurred?	☐ No Yes ☐
Estimated Degree of Disability — Will patient be disabled from work 5 days or more?	☐ No Yes ☐ *
Estimate how long patient will be off work due to this injury or disease	(Weeks) *
Will injury or occupational disease likely result in permanent disability?	☐ Yes No ☐
Did any previous injury or disease contribute to this disability: (Explain "Yes")	☐ Yes No ☐

Date — Print Doctor's name — Doctor's signature — Degree

Address

Incidentally, our files disclose the fact that the Commission was informed by John S. Murphy that all men were hired in California for work in Nevada.

If the number of lung claims keep on increasing as they have in the past several weeks, most of your time will be spent on asbestosis and pneumoconiosis claims. Seriously though, it is important that we cooperate with our insurance carriers and give them all the help we can for two reasons. First, these claims usually result in total permanent disability which means maximum compensation awards of which we will pay our proportionate share. Second, there is some doubt that our type of work could cause asbestosis. However, since one employee collected under the California Occupational Disease Law, we have had quite a few asbestosis claims. Our only concern, where an award has been made, is to be sure we are not charged with more than our proportionate share.

If you have a duplicating machine, will you send us a copy of the C-2 form submitted.

Very truly yours,

ARMSTRONG CORK COMPANY

R. C. Schiedt, Jr.
Insurance Department

JEZ

Enclosure

J. E. Zeller, AC&S, Lancaster

Carson City, Nevada
August 24, 1959

Armstrong C & S Company
120 E. Lime Street
Lancaster, Pennsylvania

Re: Lloyd V. Viall
Claim No. OD-59-14826

Gentlemen:

Upon receipt of a completed claim form and notice of claim on the above-named it is shown that he was hired in California. Therefore, we suggest that you report this claim to the California Carrier as it would not be handled through the Nevada Industrial Commission.

Trusting this explains the handling.

Sincerely yours,

R. M. SQUIRES
Claims Examiner

RMS:mc
cc: Mr. Lloyd V. Viall
20 East Liberty St.
Reno, Nevada

Robert K. Myles, M.D.
975 Ryland Street
Reno, Nevada

RCS

Armstrong

CONTRACTING AND SUPPLY CORPORATION *Subsidiary of Armstrong Cork Company*

304 SHAW ROAD
SOUTH SAN FRANCISCO, CALIFORNIA

August 10, 1959

AUG 13 1959 WLH

Mr. R. C. Schiedt, Jr.
Insurance Department
Armstrong Cork Company
Lancaster, Pennsylvania

Subject: Lloyd V. Viall
D/A - 5-18-59
Workmen's Compensation - Nevada

Dear Mr. Schiedt:

Enclosed copy of Report of Injury or Occupational Disease, Form C-2 as requested in your letter of August 5, 1959.

Very truly yours,

ARMSTRONG CONTRACTING & SUPPLY CORP.

John S. Taylor

John S. Taylor
District Manager

DJM

Encl.

J. E. Zeller, AC&S, Lancaster

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Home Address: 5485 S. 4270 W., Kearns 18, Utah — Sex: M

Marital Status: M

Occupation and Usual Duties: Insulation Mechanic Traveler — Name state in which hired Length of employment with you in Nevada: California — How Long Employed By You?: 96 days (Months)

ACCIDENT OR EXPOSURE TO DISEASE

Accident or Exposure Occurred — Place: Bethlehem Shipyard, San Francisco, Calif. Crown Zellerbach, Antioch, Calif. Stead A.F.B., Reno, Nevada; Beale A.F.B., Marysville, Calif — Hour AM PM — Date

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	FOR N.I.C. USE ONLY	RECEIVED
Policy No..... Class..... Policy Form..... Status Clerk..... Date....., 19.....	Checked by..... APPROVED BY: EXAMINER..... DATE.....	

...MAILING BE SURE CLAIM IS COMPLETE AND LEGIBLE.

EMPLOYEE—COMPLETE THE FOLLOWING:

Name	Birthdate	Age	Sex	Marital status

Address	Occupation at time of accident-exposure	Period employed this firm

Name of Employer	Date accident-exposure reported	Supervisor to whom reported

Accident or Last Known Exposure To Cause of Disease	Place of Accident — Hour AM PM — Date	
	Type and cause: Briefly describe the accident or exposure causing injury	

Injury or Disease	Type of injury or disease	Body part(s) affected	Degree of Disability	
			No lost time ☐	Unable to work ☐
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Describe treatment used:

X-ray findings:

From information given you by employee, together with medical evidence, can you directly connect this accident or disease as job incurred?		☐ No Yes ☐
Estimated Degree of Disability	Will patient be disabled from work 5 days or more?	☐ No Yes ☐ *
	Estimate how long patient will be off work due to this injury or disease	(Weeks) *
	Will injury or occupational disease likely result in permanent disability?	☐ Yes No ☐
Did any previous injury or disease contribute to this disability: (Explain "Yes")		☐ Yes No ☐

Date Print Doctor's name Doctor's signature Degree

Address