REDACTED

1-04-82 Classified

# STANDARD FORM
# EMPLOYER'S FIRST REPORT OF INJURY OR ILLNESS

A. Send ORIGINAL to
INDUSTRIAL ACCIDENT BOARD, P. O. Box 12757, Austin, Texas, 78711 if employee is absent from work more than one day.

B. Upon termination of incapacity to employee or if incapacity extends beyond sixty day period, make supplemental report.

C. Penalty of $1,000 may be assessed for failure to comply with these instructions (Sec. 7, Article 8307, V.A.T.S. amended August 27, 1979).

SEND ONE COPY TO

- ☐ LUMBERMENS MUTUAL CASUALTY COMPANY
- ☒ AMERICAN MOTORISTS INSURANCE COMPANY
- ☐ AMERICAN MANUFACTURERS MUTUAL INSURANCE CO.
- ☐ FEDERAL KEMPER INSURANCE COMPANY

P.O. BOX 40009, MEDICAL CENTER STATION, SAN ANTONIO, TX 78229

| State's Number | Board Number<br>File:<br>Carrier: |
|---|---|
| For: | Employer: |
| Carrier's File No. | OSHA File No. |
| (The spaces above are not to be completed by the Employer) | |

**EMPLOYER**

1. Name of Employer E. I. du Pont de Nemours & Co. Telephone # (512) 572-111
2. Office address: No. and St. P. O. Box 2626 City or Town Victoria, State TX 77902
3. Insured by ☐ LUMBERMENS MUTUAL CASUALTY COMPANY ☐ AMERICAN MANUFACTURERS MUTUAL INSURANCE COMPANY Policy No. 33119
   ☒ AMERICAN MOTORISTS INSURANCE COMPANY ☐ FEDERAL KEMPER INSURANCE COMPANY
4. Give nature of business (or article manufactured) Petrochemicals

**TIME and PLACE**

5. (a) Location of plant or place where accident occurred, # and Street ..... City .....
   Did accident occur on employer's premises? ☐ Yes ☐ No. County ..... State .....
   Department where injured ..... Department regularly employed in .....
   (b) If injured in a mine, did accident occur on surface, underground, shaft, drift or mill? .....
   (c) Was employee hired, or if a Texas resident, recruited in Texas? ☐ Yes ☐ No
   (d) If injury occurred out of Texas, on what date was employee transferred out of State? .....
6. Date of Injury Potential exposure to asbestos from 7/50 to 7/72
7. First day unable to labor No lost time 19 ..... A.M. ..... P.M. 8. Was injured paid in full for this day? .....
9. When did you or foreman first know of injury? ..... 10. Name of foreman .....

PLAINTIFF'S EXHIBIT DUP-1693

**INJURED PERSON**

| | Full First Name | Middle Initial | Last Name |
|---|---|---|---|
| 11. Name of Injured | [redacted] | [redacted] | [redacted] Social Security No. [redacted] |

12. Address: No. and St. [redacted] City or Town [redacted] State [redacted] Zip Code [redacted]
13. Telephone No. [redacted] Telephone No. Friend or Relative ..... Speak English ☒ Yes ☐ No
14. (a) Age 59 (b) Sex Male (c) Marital Status Married (d) Minor Children No
15. (a) Occupation when injured ..... (b) Was this his or her regular occupation? .....
    (c) Under what classification code is employee's payroll reported to insurance carrier? .....
16. (a) How long employed by you ..... (b) Piece or time worker ..... (c) Wages per hour $ .....
17. (a) No. hours per day ..... (b) Wages per day $ ..... (c) No. days worked per week ..... (d) Average weekly earnings $ .....
    (e) If board, lodging, fuel or other advantages were furnished in addition to wages, give estimated market value per day, week or month .....
18. Was injured employee officer, director, partner, or owner? Employee

**CAUSE of INJURY**

19. Machine, tool or thing causing injury Asbestos, if exposed 20. Kind of power (hand, foot, electric, steam, etc.) ..... 21. Part of machine on which accident occurred .....
22. (a) Name the safety appliance or regulation provided ..... (b) Was it in use at time? .....
23. Was accident caused by injured's failure to use or observe safety appliance or regulation? .....
24. Describe fully how accident occurred, and state what employee was doing when injured Engineer: Const.-7/50. Engineer: Nylon-2/55. Div.Supt.: S/S-11/55, Nylon-10/56, Nylon-1/59, F Unit-10/59, "Alathon"-2/60, "Alathon"-7/60, Nylon-4/65, Nylon-3/66, F Unit-1/71. Empl.Rel.Supt.: Empl.Rel.-7/74. Potential exposure to asbestos from 7/50 to 7/72.
25. Names and addresses of witnesses .....

**NATURE of INJURY**

26. Describe the injury or illness in detail and indicate the part of body affected Benign asymptomatic abnormalities. Pleural changes not resulting in disability.
27. Probable length of disability No lost time. Continue on same job at same pay rate. 28. Has injured returned to work?
    If so, date and hour ..... At what wage $ .....
29. At what occupation? .....
30. (a) Name and address of physician (if known) See attached list.
    (b) Name and address of hospital (if known) .....

DU 009337

**FATAL CASES**

31. Has injured died? No If so, give date of death .....

Date of this report ..... Firm Name .....

Signed by ..... Official Title .....

I.A.B. Form E 1 (Rev. 8-79)
EF 301 1 SA 10-79 1M

INDUSTRIAL ACCIDENT BOARD REQUIRES COMPLETION OF ALL APPLICABLE ITEMS ON THIS FORM

DUP 0810342

Question 30:

Max Faykus
Walter Herbst
James Neumann
John Starkey
VICTORIA RADIOLOGY ASSOCIATES
2710 Hospital Drive
Victoria, TX 77901

Dr. Daniel Jenkins, M.D.
BAYLOR COLLEGE OF MEDICINE
6560 Fannin, 1608 Scurlock Tower
Houston, TX 77030