

FILE NAME: Insulators Workers' Comp Claims (IWC)

DATE: 1959

DOC#: IWC027

DOCUMENT DESCRIPTION: Claimant - Viall, Lloyd, V.

Claimant

Hoyd U. Viall

State

Nevada

Initial Claim

Armstrong Cont and Supply

Date

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
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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 96 days	How Long Employed By You? (Months)
ACCIDENT OR EXPOSURE TO DISEASE	Accident or Exposure Occurred	Bethlehem Shipyard, San Francisco, Calif. Crown Zellerbach, Antioch, Calif. Stead A.F.B., Reno, Nevada; Beale A.F.B., Marysville, Calif.			
	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
	If and when doctor says employee may do light work, will you have such work available?	If workload requires		Date back on Job	Did not return *
	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..... 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	<i>[Signature]</i>	Title	District Manager
			FOR N.I.C. USE ONLY		RECEIVED	
Policy No.....			Checked by.....			
Class.....			APPROVED BY: EXAMINER.....			
Policy Form.....			DATE.....			
Status Clerk.....						
Date.....	19					

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 _____

Mr. J. S. Taylor

- 2 -

August 5, 1959

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

GRANT SAWYER
GOVERNOR

STATE OF NEVADA

GUY A. PERKINS
CHAIRMAN

NEVADA INDUSTRIAL COMMISSION



T. L. HUTCHINGS
COMMISSIONER REPRESENTING LABOR
W. G. EMMINGER
COMMISSIONER REPRESENTING INDUSTRY

ADDRESS ALL CORRESPONDENCE TO
NEVADA INDUSTRIAL COMMISSION

REPLY TO

Carson City, Nevada
August 24, 1959

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

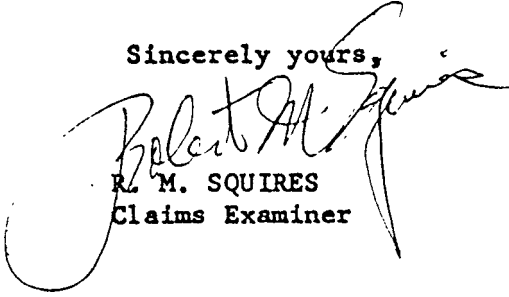
Re: Lloyd V. Viall
Claim No. OD-59-14826

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



CONTRACTING AND SUPPLY
CORPORATION *Subsidiary of Armstrong Cork Company*

304 SHAW ROAD
SOUTH SAN FRANCISCO, CALIFORNIA

August 10, 1959

LAG 23 1959 WLF

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

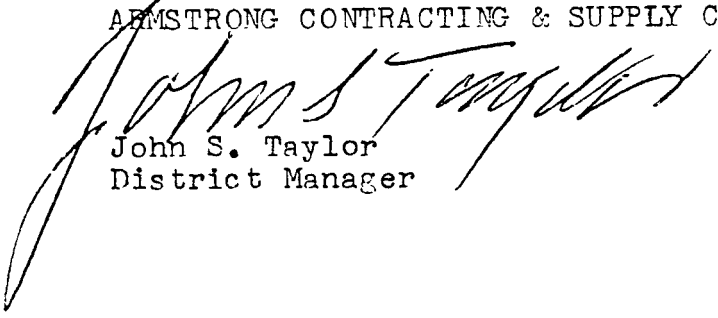
Subject: Lloyd V. Viall
D/A - 5-18-59
Workmen's Compensation - Nevada

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
District Manager

DJM

Encl.

J. E. Zeller, AC&S, Lancaster .

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	Home Address	5485 S. 4270 W., Kearns 18, Utah		M Sex		
	Occupation and Usual Duties	Insulation Mechanic Traveler	Name state in which hired Length of employment with you in Nevada	California 96 days (Months)		
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	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) *	
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How many total dependents does injured claim for tax purposes?	7 *					

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Date report completed	August 10, 19 59	Signed by	<i>[Signature]</i>	Title	District Manager
		FOR N.I.C. USE ONLY		RECEIVED	
Policy No.....	Checked by.....				
Class.....	APPROVED BY: EXAMINER.....				
Policy Form.....	DATE.....				
Status Clerk.....					
Date....., 19.....					

HANDLING REQUIRE 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 ☐ Date last worked Date returned to work		

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	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 _____