

COMMONWEALTH OF PENNSYLVANIA
DEPARTMENT OF LABOR AND INDUSTRY
BUREAU OF OCCUPATIONAL
INJURY AND DISEASE COMPENSATION
HARRISBURG 17120

EMPLOYEE'S CLAIM PETITION FOR COMPENSATION
UNDER THE
PENNSYLVANIA WORKMEN'S COMPENSATION ACT
OF 1915, AS REENACTED AND AMENDED

(TYPE OR PRINT CLEARLY)



CLAIMANT

S. J. Bassel

AND NUMBER OR R.D. NUMBER

1 Road

TOWN

COUNTY

STATE

ZIP CODE

Ball Delaware Pa

19008

Vs.

SOCIAL SECURITY NO.

182-05-0186

DATE OF BIRTH

10/1/07

TELEPHONE

356-1468

AREA CODE

215

PART EMPLOYER

Winghouse - Team Turbine Division

AND NUMBER

Industrial Highway

TOWN

STATE

ZIP CODE

ter

Pa

19113

INSURANCE CARRIER

STREET AND NUMBER

CITY OR TOWN

STATE

ZIP CODE

OUR HONORABLE REFEREE:

above named claimant respectfully alleges the following facts:

the nature of my employer's business was Manufacturing steam turbines

the nature of my occupation was Lagger - insulated turbines

DESCRIBE YOUR WORK INCLUDING TITLE, IF ANY

The date of my injury was exact date unknown

My injury occurred on employer's premises ☒ If not, state exact location, including county or state:

My injury or disease occurred in the following manner inhalation/ingestion of insulating materials.

DESCRIBE FULLY THE EVENTS WHICH RESULTED IN YOUR INJURY OR DISEASE

The nature of my injury or disease is chronic obstructive pulmonary disease heart; cardiac involvement; malignant tumor left leg.

DESCRIBE FULLY, INCLUDING PARTS OF BODY AFFECTED

If claim is for OCCUPATIONAL DISEASE under Section 108, complete the following additional information:

a. I became (totally) (partially) disabled as a result of the above occupational disease

on EXACT DATE UNKNOWN

b. My last exposure after June 30, 1973, to the hazard of the above occupational disease was

from D.N.A., 19 , to , 19 , while employed by

c. Prior to June 30, 1973, I was exposed to the hazard of the above occupational disease while employed by:

NAME ALL EMPLOYERS

DATES OF EMPLOYMENT

FROM

TO

Winghouse; Foster, Pa.

4/42

11/72

28006483

I was treated by the following doctors and/or hospitals:

Reynolds Memorial Hosp. Tel. Del. Co. Memorial Hosp

GIVE NAMES AND ADDRESSES. IF NONE, SO STATE.

Dr. Hengeman, Canton, Ohio and others

9. a. I did NOT request my employer to furnish the above medical and hospital services.

b. The employer did NOT furnish these services.

c. The amount spent by me for all or part of these services was \$ will admit

10. I was disabled due to my injury or disease from EXACT DATE UNKNOWN to present

11. I have NOT returned to work at my previous occupation and at my former wages, which were \$ 14,500 -

12. Notice of my injury or disease was served upon my employer on 1ST NOTICE 1963 (date) by me in the following manner:

had a heart attack while on Company Business in Texas in 1963.

STATE TO WHOM AND HOW NOTICE WAS GIVEN

13. I believe the following additional facts to be important:

I have been exposed to
great amounts of asbestos for almost 30 yrs.
In Dec. 1975 my doctor said "I have asbesthosis"

WHEREFORE, I ask that your honorable Referee issue an award of compensation to me in accordance with the provisions of the Pennsylvania Workmen's Compensation Act.

Thomas J. Nassel
NAME

Subscribed and sworn to before me on this 21st day of June, 1976 at Brownell
Pennsylvania

Ray M. [Signature]

(This affidavit may be sworn before a compensation referee or any person authorized to administer an oath.)

PLEASE ENTER MY APPEARANCE FOR PETITIONER:

ATTORNEY

Melvin Brookman

ADDRESS

505 Land Title Bldg
Phila Pa 19110.

NOTE: This petition should be filed in original and five exact copies either typed or printed. It is only necessary to make affidavit to the original petition.

2B006484

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