OD-4

INSTRUCTIONS: Under R. C. 4123.28 of the Workmen's Compensation Act, every employer shall keep a record of ALL injuries and occupational disease disabilities received by his employees in the course of employment and report same to the Bureau of Workmen's Compensation. This form OD-4 is to be used only in cases where the occupational disease causes a disability of MORE THAN ONE WEEK. It should be completed and signed by the disabled employee and his employer and mailed to the nearest office of the Bureau of Workmen's Compensation. Office addresses on reverse side of this application.

STATE OF OHIO
BUREAU OF WORKMEN'S COMPENSATION

Claim No. O. D. 106226

PART I. **Claimant's Report of Occupational Disease**

1. CLAIMANT'S NAME: CLARENCE (First) A. (Middle Initial) HULETTE (Last)
2. Home Address: 429 (Number) MILL (Street) LOCKLAND (City) HAMILTON (County) Ohio (State)
3. Age: 61 Social Security No. 270-05-6880 Employer: PHILIP CAREY MFG Co
   Occupation: JANITOR (Welder, etc.) No. and relationship of dependents: ONE - WIFE
4. From what disease are you suffering? ASBESLOTIS
5. What parts of the body are affected? LUNGS + THROAT
   Give date your symptoms first appeared: 1943 Name of employer when symptoms appeared: PHILIP CAREY MFG Co. How long in employ of this employer before symptoms first appeared:
6. Location of plant where you worked, when disability began: LOCKLAND Ohio HAMILTON Co (County and City)
7. When were symptoms first reported to employer? DEC. 1946
8. Describe exactly how you were exposed to the substance, which, in your opinion caused your disease: DUST IN THE BEATER ROOM CAUSED BY ASBESTOS WHICH WAS PUT IN BEATERS.
9. Give name and address of physician who first diagnosed your disease as being occupational, and date diagnosis made: DR. JACOBS BURNS AVE. WYOMING Ohio
10. Have you previously suffered from the disease for which this application is made, or any other occupational disease? 1946-1951 If so, give details (dates of attacks, name and address of physician) DR. CHAVANAUGH BENSON, READING
11. Date quit work: DECEMBER 1946 For what reason? THE DOCTORS ORDERS
12. Date returned to work: JAN. 1947 Type of work: JANITOR
13. Occupation when disability began: BEATER MAN Type of work you were doing when disability began: BEATERMAN - ASBESTOS STOCK Length of time in this type of work (a) immediately prior to onset of symptoms: 18 YEARS 3 MONTHS
    (b) During lifetime: 25 YEARS
14. Were you exposed to dust in your work? YES Type of dust: ASBESTOS
    Describe briefly how you were exposed: WORKING IN THE BEATER ROOM DUST GOT THROUGH RESPIRATOR
    Over what periods were you exposed in your employment? EIGHT + TWELVE HOURS A DAY
    Date of last exposure to dust: DEC. 12, 1953
15. If you were exposed to the substance which allegedly caused this disease in other employments, give the names and addresses of the other employers, and dates of employments: NONE
16. Have you filed a previous application concerning this or any other occupational disease? If so, give claim number: O.D. 47978

We are the authorized representatives of this employer [illegible] person who shall have any interest in this claim, [illegible] are attended or examined me, or who hereafter [illegible] they thereby acquired. I have read all the state- [illegible] authorize the Bureau of Workmen's Compensation [illegible] services pursuant to this application for pay [illegible] and Notices of Findings to:

JOHN T. CANTLON & ASSOCIATES, INC.
40 WEST THIRD AVENUE COLUM[illegible]

[illegible] (Claimant. If unable to sign, mark must be made.)
429 Mill Street
City or Town: Lockland 15, Ohio

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INPUT TO COMPUTER

PART II. **Employer's Report of Occupational Disease**

1. Name of employer: The Philip Carey Mfg. Company (Name as shown on Insurance Certificate)
2. Office address: Wayne Ave. Lockland, Cinti. 15, Ohio (Number) (Street) (City)
3. Nature of business: Manufacturing (Farming, coal mining, etc.) Type of organization: Corporation (Corp., Partnership, Individual)
4. The earnings of the injured employee for services rendered at time of occupational disease are being reported on payroll reports of Risk No. 1684 Manual No. 4233

PLAINTIFF'S EXHIBIT

O.R.

ACE 11

Do not write in this column	
Age	61
Sex & c.c.	1
Dependents	01
Location (Geo.)	311
Date Report Filed	7/48
Date of Disab.	12-46
Report Lag	---
Hearing Lag	
Payment Lag	
Occupation	7[illegible]
Experience	9
Agency (Disease)	7[illegible]
Agency Part	[illegible]
Type of Disease	[illegible]
Nature of Disab.	90
Part of Body	2[illegible]
Full Wage	
Average Wage	
Treatment	
Complicat.	
Degree of I	M
Days L.	[illegible]
Coded by	9
Manual No.	423[illegible]
Risk No.	1684

6. Is it your opinion that claimant contracted an occupational disease in your plant?

7. Do you agree with statements of claimant? If not, indicate the points of disagreement:

8. The following is a statement of wages earned each week by the injured employee during the period of one year immediately prior to date of disability June 15, 19 57 to June 15, 19 56;
Show total earnings—Make no deductions for Social Security, Old Age Pensions, Insurance or Unemployment Compensation.

For week ending	Amount of earnings during week	No. days employed during week	For week ending	Amount of earnings during week	No. days employed during week
6/16/57	91.00	6	12/22/57	91.00	6
23	91.00	6	29	64.75	5
30	119.00	7	1/ 5/58	89.25	6
7/ 7	96.51	6½	12	84.00	6
14	119.00	7	19	84.00	6
21	119.00	7	26	70.00	5
28	119.00	7	2/ 2	70.00	5
8/ 4	91.00	6	9	70.00	5
11	91.00	6	16	70.00	5
18	119.00	7	23	70.00	5
25	91.00	6	3/ 2	56.00	5
9/ 1	91.08	6	9	84.00	6
8	91.00	6	16	70.00	5
15	91.00	6	23	56.00	4
22	91.17	6	30	70.00	5
29	91.00	6	4/ 6	70.00	5
10/6	107.25	7	13	70.00	4
13	101.90	7	20	56.00	4
20	101.90	7	27	70.00	5
27	101.81	7	5/ 4	70.00	5
11/3	84.00	6	*		
10	91.00	6	6/ 1	60.30	4
17	84.00	6	8	72.00	5
24	84.16	6	15	72.00	5
12/1	84.00	3			
8	70.00	5			
15	91.00	6			

9. If meals, lodging, tips, etc., were received in addition to wages, describe and state weekly value $

10. Will employee receive wages or meals and lodging during period of disability?
Indicate what part, if any:

11. If employee did not work on any days during the period shown on Wage Report (Item 6), state reasons: (Personal, plant shut down, other injuries, illness, etc.) * 3 weeks - Work Stoppage

By signing below, I do hereby certify that I have authority to execute this Employer's Report and that the answers to the questions given in said report are correct to the best of my information and belief. By signing this report, the employer certifies that this is a valid claim, requests that compensation be paid claimant forthwith and waives notice of receipt of claim as well as notice of order of compensation from the Bureau of Workmen's Compensation Administrator as provided in R. C. 4123.512-513.

P.W.W.	
A.W.W.	

(Name of person signing report)

SAFETY SUPERVISOR
(Official title of person signing and his department)

For THE PHILIP CAREY MFG. CO.
(Name of employer as shown on Insurance Certificate)

Bureau Offices

ron	807 United Bldg.	Logan	51½ E. Main St.
Canton	601 Market Avenue S.	Mansfield	405 Farmers Bank Bldg.
Cincinnati	41 Duttenhofer Bldg.	Martins Ferry	Cor. 4th & Walnut Sts.
Cleveland	414 Superior Avenue, W.	Portsmouth	302 Masonic Temple
Columbus	State Office Bldg.	Springfield	31 E. High Street
Dayton	3rd & Jefferson Sts.	Toledo	508 Richardson Bldg
Hamilton	422 Rentschler Bldg.	Youngstown	803 Realty Bldg.
Lima	400 Colonial Bldg.	Zanesville	302 Masonic Bldg.