PLAINTIFF'S EXHIBIT

UC-3413

24 A92

UC 149-2

UNION CARBIDE

INTERNAL CORRESPONDENCE

AGRICULTURAL PRODUCTS COMPANY, INC. • P.O. BOX 2831, CHARLESTON, WEST VIRGINIA 25330

INSTITUTE PLANT

To (Name) L. R. Noble, 511-2149
Division
Location Location 512
Floor Number

Date 12 August 80

Originating Dept. Medical Department - 512

Floor Number

Copy to Charles W. Carman, 725-105, Loc. 511
E. C. Shipley, 511-2009, Loc. 512
D. R. Paugh, 511-2009, Loc. 512

Answering letter date

Subject Medical Surveillance for Asbestosis - 1980
936 and 938 Employees

Commencing on 23 April 1980 and ending today, a total of 147 active construction employees were offered medical surveillance for asbestosis according to the OSHA standard. There were 4 construction employees who refused to be examined and there were 10 retired construction employees who accepted the Medical Department's offer to be examined.

Up until 1980 the New York Legal Department has recommended that Corporation employees with medical evidence of asbestosis not be entered on OSHA Log 200 because these employees were not ill and did not require treatment even though they had medical evidence of asbestosis. Suddenly in late 1979, they recommended that any employee of the Corporation showing evidence of asbestosis be entered on the OSHA Log 200. As an attachment to this letter, I am listing names of those active employees who obviously have pneumoconiosis with asbestosis or in several sand-blasters, silicosis. I suggest that these names be entered on the OSHA Log 200 as recommended by the New York Legal Department.

Very truly yours,

R. J. Sexton, M.D.
Plant Medical Director

RJS:jfc
Attachment

UCC 01716

F

OSHA INJURY CATEGORY: A LWD | B | O | MINOR | NAI

EMPLOYEE INJURY REPORT

NATURE OF INJURY: 1 ABRASION | 2 AMPUTATION | 3 BURN (TEMP) | 4 BURN (CHEM) | 5 CONTUSION | 6 DERMATITIS | 7 DISLOCATION | 8 ELEC SHOCK | 9 FRACTURE | 10 FREEZING | 11 HEARING LOSS | 12 HEAT STROKE | 13 HERNIA | 14 LACERATION | 15 POISONING | 16 PNEUMOCONIOSIS | 17 RADIATION | 18 SCRATCHES | 19 SPRAIN | 20 MULTIPLE

PART OF BODY AFFECTED (PER USAS Z 16.2 A1.2): 120 | 130 | 140 | 150 | 200 | 311 | 313 | 315 | 320 | 330 | 340 | 410 | 420 | 430 | 440 | 450 | 511 | 513 | 515 | 520 | 530 | 540 | 700 | 850

UNION CARBIDE CORPORATION
CHEMICALS AND PLASTICS
INSTITUTE PLANT - LOCATION 512

DISABLING NO. _____
OSHA NO _____

NAME: Adams, H. M. JOB CLASSIFICATION Painter Ins. SOC SEC. NO. _____ PAYROLL NUMBER 95645 4041 (HR) SAL. (CIRCLE ONE)

DATE INJURY OCCURRED: DATE REPORTED: 26 Aug 80 TIME OF INJURY: (COMPLETE)

DESCRIPTION OF INJURY: Contact Asbestos Med. Surv.

RX:

CAUSE: 11 yrs. exposure

WORK RESTRICTIONS

ACCIDENT TYPE (PER USAS Z 16.2 A1.4): 10 | 20 | 30 | 50 | 60 | 80 | 100 | 120 | 130 | 150 | 181 | 182 | 183 | 200 | 300 | 899 | 999

SUPERVISOR WHEN INJURY OCCURRED:

IF SHIFT WORKER. CIRCLE SHIFT WORKING WHEN INJURY OCCURRED: A B C D

BUILDING NUMBER. AREA, OR UNIT WHERE INJURY OCCURRED:

CIRCLE COMPLEX IN WHICH EMPLOYEE WAS WORKING WHEN INJURY OCCURRED: 1 2 3 4 5 6 7 8

IF OTHER DEPARTMENT. CIRCLE LOCATION WHERE INJURY OCCURRED: OFFICE ENGINEERING DISTRIBUTION LABORATORY MAT'LS MGMT SHIFT UTILITY MECH.

CHECK YES OR NO IN PROVIDED SPACE WHETHER OR NOT SAFETY EQUIPMENT WAS BEING USED:

	YES	NO		YES	NO	RESPIRATOR.	YES	NO
SAFETY GLASSES	☐	☐	SAFETY SHOES	☐	☐	AIR LINE	☐	☐
COVERALL GOGGLES	☐	☐	INSTEP GUARD	☐	☐	SELF-CONTAINED	☐	☐
FACE SHIELD	☐	☐	PLASTIC, LEATHER OR RUBBER GLOVES	☐	☐	CHEMICAL CARTRIDGE	☐	☐
PVC CLOTHING	☐	☐				DUST CARTRIDGE	☐	☐
COVERALLS	☐	☐	HARD HAT	☐	☐	EXPENDABLE	☐	☐
BOOTS	☐	☐	EAR PROTECTION	☐	☐	AIR CAPSULE OR SKA-PAK	☐	☐

SIGNATURE OF EMPLOYEE

M. Pitts
ATTENDING NURSE

WITNESS

DISTRIBUTION OF REPORT: WHITE COPY IS FOR THE SAFETY DEPT; YELLOW FOR DEPT. HEAD AND SHIFT SUPT

1ST AND 2ND COPIES ARE TO BE GIVEN TO THE INJURED EMPLOYEE BEFORE HE LEAVES THE MEDICAL DEPARTMENT HE WILL DELIVER THEM TO HIS SUPERVISOR WHO IS TO COMPLETE THE INJURY INVESTIGATION REPORT ON THE REVERSE

MONTH: J F M A M J J A S O N D

UNSAFE ACT (USAS Z16.2 A1.8): 66 | 75 | 65 | 60 | 55 | 50 | 45 | 40 | 35 | 30 | 25 | 20 | 15 | 10 | 05

HAZARDOUS COND.: X | 9 | 8 | 7 | 6 | 5 | 4 | 3 | 2 | 1 | 0

SOURCE OF INJURY: 1 4 5 6 7 9 13 15 17 19 20 22 23 | 25 26 28 30 41 44 46 49 50 54 56 57 58

SEX: M F

SHIFT: A B C D

OPN./MAINT. COMPLEX: 9 8 7 6 5 4 3 2 1

DEPARTMENT NUMBER: 938 | 010 | 391 | 355 | 342 | 327 | 308 | 229 | 227 | 220 | 167 | 166 | 165 | 162 | 161 | 158 | 157 | 156 | 146 | 140 | 135 | 127 | 106 | 095 | 086 | 061 | 059 | 047 | 044 | 041 | 035 | 033 | 004 | 003

INFORMATION FOR OSHA LOG 200

Extent of and Outcome of INJURY

Fatalities	Nonfatal Injuries				
	Injuries With Lost Workdays				Injuries Without Lost Workdays
Injury Related Enter DATE of death Mo./day/yr. (1)	Enter a CHECK if injury involves days away from work, or days of restricted work activity, or both. (2)	Enter a CHECK if injury involves days away from work. (3)	Enter number of DAYS away from work. (4)	Enter number of DAYS of restricted work activity. (5)	Enter a CHECK if no entry was made in columns 1 or 2 but the injury is recordable as defined above. (6)

LOST WORK DAYS

	(A) DAYS AWAY FROM WORK		(B) DAYS OF RESTRICTED WORK ACTIVITY	
Date	START	RETURN	START	RETURN
No. of Days	LOST (A):		LOST (B):	

Type, Extent of, and Outcome of ILLNESS

Type of Illness	Fatalities	Nonfatal Illnesses				
CHECK Only One Column for Each Illness (See other side of form for terminations or permanent transfers.)	Illness Related Enter DATE of death Mo./day/yr. (8)	Illnesses With Lost Workdays				Illnesses Without Lost Workdays
		Enter a CHECK if illness involves days away from work, or days of restricted work activity, or both. (9)	Enter a CHECK if illness involves days away from work. (10)	Enter number of DAYS away from work. (11)	Enter number of DAYS of restricted work activity. (12)	Enter a CHECK if no entry was made in columns 8 or 9. (13)

(7)						
Occupational skin diseases or disorders	Dust diseases of the lung	Respiratory conditons due to toxic agents	Poisoning (systemic effects of toxic materials)	Disorders due to physical agents	Disorders associated with repeated trauma	All other occupational illnesses
(a)	(b)	(c)	(d)	(e)	(f)	(g)

Was a preliminary investigation held? _____ When? _____

Who attended? _____

Comments

REVISED APRIL 1978

UCC 017167

UCC 017168

OSHA INJURY CATEGORY: A LWD | B MINOR | O NAI.

EMPLOYEE INJURY REPORT

NATURE OF INJURY: 1 ABRASION; 2 AMPUTATION; 3 BURN (TEMP); 4 BURN (CHEM); 5 CONTUSION; 6 DERMATITIS; 7 DISLOCATION; 8 ELEC SHOCK; 9 FRACTURE; 10 FREEZING; 11 HEARING LOSS; 12 HEAT STROKE; 13 HERNIA; 14 LACERATION; 15 POISONING; 16 PNEUMOCONIOSIS; 17 RADIATION; 18 SCRATCHES; 19 SPRAIN; 20 MULTIPLE

PART OF BODY AFFECTED (PER USAS Z 16.2 A1.2): 120; 130; 140; 150; 200; 311; 313; 315; 320; 330; 340; 410; 420; 430; 440; 450; 511; 513; 515; 520; 530; 540; 700; 850

UNION CARBIDE CORPORATION
CHEMICALS AND PLASTICS
INSTITUTE PLANT - LOCATION 512

DISABLING NO. _____
OSHA NO. _____

NAME: Bays, J.R. JOB CLASSIFICATION: Insulator Shop SOC. SEC. NO. ___-__-____ PAYROLL NUMBER: 3755 3485 (HR) SAL. (CIRCLE ONE)

DATE INJURY OCCURRED: TIME OF INJURY: (COMPLETE) DATE REPORTED: 26 Aug 80

DESCRIPTION OF INJURY: Annual Occ. Med. Exam

RX:

CAUSE: 28 yrs exposure

WORK RESTRICTIONS

SUPERVISOR WHEN INJURY OCCURRED:

IF SHIFT WORKER, CIRCLE SHIFT WORKING WHEN INJURY OCCURRED: A B C D

BUILDING NUMBER, AREA, OR UNIT WHERE INJURY OCCURRED:

CIRCLE COMPLEX IN WHICH EMPLOYEE WAS WORKING WHEN INJURY OCCURRED: 1 2 3 4 5 6 7 8

IF OTHER DEPARTMENT, CIRCLE LOCATION WHERE INJURY OCCURRED: OFFICE ENGINEERING DISTRIBUTION LABORATORY MAT'LS MGMT SHIFT UTILITY MECH.

CHECK YES OR NO IN PROVIDED SPACE WHETHER OR NOT SAFETY EQUIPMENT WAS BEING USED:

	YES	NO		YES	NO	RESPIRATOR:	YES	NO
SAFETY GLASSES	☐	☐	SAFETY SHOES	☐	☐	AIR LINE	☐	☐
COVERALL GOGGLES	☐	☐	INSTEP GUARD	☐	☐	SELF-CONTAINED	☐	☐
FACE SHIELD	☐	☐	PLASTIC, LEATHER OR RUBBER GLOVES	☐	☐	CHEMICAL CARTRIDGE	☐	☐
PVC CLOTHING	☐	☐	HARD HAT	☐	☐	DUST CARTRIDGE	☐	☐
COVERALLS	☐	☐	EAR PROTECTION	☐	☐	EXPENDABLE	☐	☐
BOOTS	☐	☐				AIR CAPSULE OR SKA-PAK	☐	☐

SIGNATURE OF EMPLOYEE

ATTENDING NURSE: D. Pitt

WITNESS

DISTRIBUTION OF REPORT: WHITE COPY IS FOR THE SAFETY DEPT.; YELLOW FOR DEPT. HEAD AND SHIFT SUPT

1ST AND 2ND COPIES ARE TO BE GIVEN TO THE INJURED EMPLOYEE BEFORE HE LEAVES THE MEDICAL DEPARTMENT. HE WILL DELIVER THEM TO HIS SUPERVISOR WHO IS TO COMPLETE THE INJURY INVESTIGATION REPORT ON THE REVERSE

OPN./MAINT. COMPLEX: X 9 8 7 6 5 4 3 2 1

DEPARTMENT NUMBER: 938; 010; 391; 355; 342; 327; 308; 229; 227; 220; 167; 166; 165; 162; 161; 158; 157; 156; 146; 140; 135; 127; 106; 095; 086; 061; 059; 047; 044; 041; 035; 033; 00A; 003

ACCIDENT TYPE (PER USAS Z 16.2 A1.4): 10; 20; 30; 50; 60; 80; 100; 120; 130; 150; 181; 182; 183; 200; 300; 899; 999

SOURCE OF INJURY: 1 4 5 6 7 9 13 15 17 19 20 22 23 25 26 28 30 41 44 46 49 50 54 56 57 58

SEX: M F

SHIFT: A B C D

MONTH: J F M A M J J A S O N D

UNSAFE ACT (USAS Z16.2 A1.8): 66 75 65 60 55 50 45 40 35 30 25 20 15 10 05

HAZARDOUS COND.: 0 1 2 3 4 5 6 7 8 9

EMPLOYEE INJURY REPORT

OSHA INJURY CATEGORY: A LWD | B O | MINOR NAI.

NATURE OF INJURY: 1 ABRASION | 2 AMPUTATION | 3 BURN (TEMP) | 4 BURN (CHEM) | 5 CONTUSION | 6 DERMATITIS | 7 DISLOCATION | 8 ELEC SHOCK | 9 FRACTURE | 10 FREEZING | 11 HEARING LOSS | 12 HEAT STROKE | 13 HERNIA | 14 LACERATION | 15 POISONING | 16 PNEUMOCONIOSIS | 17 RADIATION | 18 SCRATCHES | 19 SPRAIN | 20 MULTIPLE

PART OF BODY AFFECTED (PER USAS Z 16.2 A1.2): 120 | 130 | 140 | 150 | 200 | 311 | 313 | 315 | 320 | 330 | 340 | 410 | 420 | 430 | 440 | 450 | 511 | 513 | 515 | 520 | 530 | 540 | 700 | 850

ACCIDENT TYPE (PER USAS Z 16.2 A1.4): 10 | 20 | 30 | 50 | 60 | 80 | 100 | 120 | 130 | 150 | 181 | 182 | 183 | 200 | 300 | 899 | 999

UNION CARBIDE CORPORATION
CHEMICALS AND PLASTICS
INSTITUTE PLANT - LOCATION 512

DISABLING NO. _____
OSHA NO. _____

NAME: Bryan, C L. JOB CLASSIFICATION Laborer

SOC. SEC. NO _____

PAYROLL NUMBER 43659 530 (HR.) SAL. (CIRCLE ONE)

DATE INJURY OCCURRED: DATE REPORTED: 26 Aug 80

TIME OF INJURY: (COMPLETE)

DESCRIPTION OF INJURY: Annual Asb Medical Exam

RX:

CAUSE: 25 yrs exposure

WORK RESTRICTIONS

SUPERVISOR WHEN INJURY OCCURRED:

IF SHIFT WORKER, CIRCLE SHIFT WORKING WHEN INJURY OCCURRED: A B C D

BUILDING NUMBER, AREA, OR UNIT WHERE INJURY OCCURRED:

CIRCLE COMPLEX IN WHICH EMPLOYEE WAS WORKING WHEN INJURY OCCURRED: 1 2 3 4 5 6 7 8

IF OTHER DEPARTMENT, CIRCLE LOCATION WHERE INJURY OCCURRED: OFFICE ENGINEERING DISTRIBUTION LABORATORY MAT'LS MGMT SHIFT UTILITY MECH.

CHECK YES OR NO IN PROVIDED SPACE WHETHER OR NOT SAFETY EQUIPMENT WAS BEING USED.

	YES	NO		YES	NO	RESPIRATOR:	YES	NO
SAFETY GLASSES	☐	☐	SAFETY SHOES	☐	☐	AIR LINE	☐	☐
COVERALL GOGGLES	☐	☐	INSTEP GUARD	☐	☐	SELF-CONTAINED	☐	☐
FACE SHIELD	☐	☐				CHEMICAL CARTRIDGE	☐	☐
PVC CLOTHING	☐	☐	PLASTIC, LEATHER OR RUBBER GLOVES	☐	☐	DUST CARTRIDGE	☐	☐
COVERALLS	☐	☐	HARD HAT	☐	☐	EXPENDABLE	☐	☐
BOOTS	☐	☐	EAR PROTECTION	☐	☐	AIR CAPSULE OR SKA-PAK	☐	☐

SIGNATURE OF EMPLOYEE

ATTENDING NURSE M Pitts

WITNESS

DISTRIBUTION OF REPORT: WHITE COPY IS FOR THE SAFETY DEPT.; YELLOW FOR DEPT. HEAD AND SHIFT SUPT

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McGEE SYSTEMS M18019X

OPN./MAINT. COMPLEX: X 9 8 7 6 5 4 3 2 1

DEPARTMENT NUMBER: 938 | 010 | 391 | 355 | 342 | 327 | 308 | 229 | 227 | 220 | 167 | 166 | 165 | 162 | 161 | 158 | 157 | 156 | 146 | 140 | 135 | 127 | 106 | 095 | 086 | 061 | 059 | 047 | 044 | 041 | 035 | 033 | 003

SOURCE OF INJURY: 1 4 5 6 7 9 13 15 17 19 20 22 23 | 25 26 28 30 41 44 46 49 50 54 56 57 58

SEX: M F

SHIFT: A B C D

MONTH: J F M A M J J A S O N D

UNSAFE ACT (USAS Z16.2 A1.8): 05 10 15 20 25 30 35 40 45 50 55 60 65 75 66

HAZARDOUS COND.: 0 1 2 3 4 5 6 7 8 9

UCC 01769

OSHA INJURY CATEGORY: A LWD | B O | MINOR NAI.

EMPLOYEE INJURY REPORT

NATURE OF INJURY: 1 ABRASION; 2 AMPUTATION; 3 BURN (TEMP); 4 BURN (CHEM); 5 CONTUSION; 6 DERMATITIS; 7 DISLOCATION; 8 ELEC. SHOCK; 9 FRACTURE; 10 FREEZING; 11 HEARING LOSS; 12 HEAT STROKE; 13 HERNIA; 14 LACERATION; 15 POISONING; 16 PNEUMOCONIOSIS; 17 RADIATION; 18 SCRATCHES; 19 SPRAIN; 20 MULTIPLE

PART OF BODY AFFECTED (PER USAS Z 16.2 A1.2): 120 130 140 150 200 311 313 315 320 330 340 410 420 430 440 450 511 513 515 520 530 540 700 850

UNION CARBIDE CORPORATION
CHEMICALS AND PLASTICS
INSTITUTE PLANT - LOCATION 512

DISABLING NO _____
OSHA NO _____

ACCIDENT TYPE (PER USAS Z 16.2 A1.4): 10 20 30 50 60 80 100 120 130 150 181 182 183 200 300 899 999

NAME Byrd, J. A. JOB CLASSIFICATION Insulator Shop SOC. SEC. NO. ___-___-____ PAYROLL NUMBER 5555 2838 (HR) SAL. (CIRCLE ONE)

DATE INJURY OCCURRED: DATE REPORTED 26 Aug 80 TIME OF INJURY (COMPLETE)

DESCRIPTION OF INJURY Ground Asbestos Med Sur

RX:

CAUSE: 19 years exposure

WORK RESTRICTIONS

SUPERVISOR WHEN INJURY OCCURRED:

IF SHIFT WORKER. CIRCLE SHIFT WORKING WHEN INJURY OCCURRED: A B C D

BUILDING NUMBER. AREA, OR UNIT WHERE INJURY OCCURRED:

CIRCLE COMPLEX IN WHICH EMPLOYEE WAS WORKING WHEN INJURY OCCURRED. 1 2 3 4 5 6 7 8

IF OTHER DEPARTMENT. CIRCLE LOCATION WHERE INJURY OCCURRED: OFFICE ENGINEERING DISTRIBUTION LABORATORY MAT'LS MGMT SHIFT UTILITY MECH.

CHECK YES OR NO IN PROVIDED SPACE WHETHER OR NOT SAFETY EQUIPMENT WAS BEING USED:

	YES	NO		YES	NO	RESPIRATOR:	YES	NO
SAFETY GLASSES	☐	☐	SAFETY SHOES	☐	☐	AIR LINE	☐	☐
COVERALL GOGGLES	☐	☐	INSTEP GUARD	☐	☐	SELF-CONTAINED	☐	☐
FACE SHIELD	☐	☐	PLASTIC, LEATHER OR			CHEMICAL CARTRIDGE	☐	☐
PVC CLOTHING	☐	☐	RUBBER GLOVES	☐	☐	DUST CARTRIDGE	☐	☐
COVERALLS	☐	☐	HARD HAT	☐	☐	EXPENDABLE	☐	☐
BOOTS	☐	☐	EAR PROTECTION	☐	☐	AIR CAPSULE OR SKA-PAK	☐	☐

SIGNATURE OF EMPLOYEE

ATTENDING NURSE D. Pitts

WITNESS

DISTRIBUTION OF REPORT: WHITE COPY IS FOR THE SAFETY DEPT.; YELLOW FOR DEPT. HEAD AND SHIFT SUPT.
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MCBEE SYSTEMS M18019X

OPN./MAINT. COMPLEX: X 9 8 7 6 5 4 3 2 1

DEPARTMENT NUMBER: 938 010 391 355 342 327 308 229 227 220 167 166 165 162 161 158 157 156 146 140 135 127 106 095 086 061 059 047 044 041 035 033 004 003

MONTH: J F M A M J J A S O N D

UNSAFE ACT (USAS Z16.2 A1.8): 66 75 65 60 55 50 45 40 35 30 25 20 15 10 05

HAZARDOUS COND.: 0 1 2 3 4 5 6 7 8 9

SOURCE OF INJURY: 1 4 5 6 7 9 13 15 17 19 20 22 23 25 26 28 30 41 44 46 49 50 54 56 57 58

SEX: M F

SHIFT: A B C D

UCC 01770

UCC 017171

EMPLOYEE INJURY REPORT

OSHA INJURY CATEGORY: A LWD | B O | MINOR NAI.

NATURE OF INJURY: 1 ABRASION; 2 AMPUTATION; 3 BURN (TEMP); 4 BURN (CHEM); 5 CONTUSION; 6 DERMATITIS; 7 DISLOCATION; 8 ELEC SHOCK; 9 FRACTURE; 10 FREEZING; 11 HEARING LOSS; 12 HEAT STROKE; 13 HERNIA; 14 LACERATION; 15 POISONING; 16 PNEUMOCONIOSIS; 17 RADIATION; 18 SCRATCHES; 19 SPRAIN; 20 MULTIPLE

PART OF BODY AFFECTED (PER USAS Z 16.2 A1.2): 120 130 140 150 200 311 313 315 320 330 340 410 420 430 440 450 511 513 515 520 530 540 700 850

ACCIDENT TYPE (PER USAS Z 16.2 A1.4): 10 20 30 50 60 80 100 120 130 150 181 182 183 200 300 899 999

SOURCE OF INJURY: 1 4 5 6 7 9 13 15 17 19 20 22 23 25 26 28 30 41 44 46 49 50 54 56 57 58

SEX: M F

SHIFT: A B C D

UNION CARBIDE CORPORATION
CHEMICALS AND PLASTICS
INSTITUTE PLANT - LOCATION 512

DISABLING NO _____

OSHA NO _____

NAME: Chandler J F

JOB CLASSIFICATION: Insulator

SOC. SEC. NO. _____

PAYROLL NUMBER: 836

HR. SAL. (CIRCLE ONE)

TIME OF INJURY (COMPLETE)

DATE INJURY OCCURRED:

DATE REPORTED: 26 Aug 80

DESCRIPTION OF INJURY: Contact Derm. Med. Store

RX:

CAUSE: 32 yrs exposure

WORK RESTRICTIONS

SUPERVISOR WHEN INJURY OCCURRED:

IF SHIFT WORKER, CIRCLE SHIFT WORKING WHEN INJURY OCCURRED: A B C D

BUILDING NUMBER, AREA, OR UNIT WHERE INJURY OCCURRED:

CIRCLE COMPLEX IN WHICH EMPLOYEE WAS WORKING WHEN INJURY OCCURRED: 1 2 3 4 5 6 7 8

IF OTHER DEPARTMENT, CIRCLE LOCATION WHERE INJURY OCCURRED: OFFICE ENGINEERING DISTRICTION LABORATORY MAT'LS MGMT SHIFT UTILITY MECH.

CHECK YES OR NO IN PROVIDED SPACE WHETHER OR NOT SAFETY EQUIPMENT WAS BEING USED:

	YES	NO		YES	NO	RESPIRATOR:	YES	NO
SAFETY GLASSES	☐	☐	SAFETY SHOES	☐	☐	AIR LINE	☐	☐
COVERALL GOGGLES	☐	☐	INSTEP GUARD	☐	☐	SELF-CONTAINED	☐	☐
FACE SHIELD	☐	☐				CHEMICAL CARTRIDGE	☐	☐
PVC CLOTHING	☐	☐	PLASTIC, LEATHER OR RUBBER GLOVES	☐	☐	DUST CARTRIDGE	☐	☐
COVERALLS	☐	☐	HARD HAT	☐	☐	EXPENDABLE	☐	☐
BOOTS	☐	☐	EAR PROTECTION	☐	☐	AIR CAPSULE OR SKA-PAK	☐	☐

SIGNATURE OF EMPLOYEE

ATTENDING NURSE: M. Petty

WITNESS

DISTRIBUTION OF REPORT: WHITE COPY IS FOR THE SAFETY DEPT.; YELLOW FOR DEPT. HEAD AND SHIFT SUPT

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MCBEE® SYSTEMS M180191

OPN./MAINT. COMPLEX: X 9 8 7 6 5 4 3 2 1

DEPARTMENT NUMBER: 938 010 391 355 342 327 308 229 227 220 167 166 155 162 161 158 157 156 146 140 135 127 106 095 086 061 059 047 044 041 035 033 004 003

MONTH: J F M A M J J A S O N D

UNSAFE ACT (USAS Z16.2 A1.8): 66 75 65 60 55 50 45 40 35 30 25 20 15 10 05

HAZARDOUS COND.: 0 1 2 3 4 5 6 7 8 9

EMPLOYEE INJURY REPORT

OSHA INJURY CATEGORY: A LWD | B | O | MINOR | NAI.

NATURE OF INJURY: 1 ABRASION; 2 AMPUTATION; 3 BURN (TEMP); 4 BURN (CHEM); 5 CONTUSION; 6 DERMATITIS; 7 DISLOCATION; 8 ELEC SHOCK; 9 FRACTURE; 10 FREEZING; 11 HEARING LOSS; 12 HEAT STROKE; 13 HERNIA; 14 LACERATION; 15 POISONING; 16 PNEUMOCONIOSIS; 17 RADIATION; 18 SCRATCHES; 19 SPRAIN; 20 MULTIPLE

PART OF BODY AFFECTED (PER USAS Z 16.2 A1.2): 120 130 140 150 200 311 313 315 320 330 340 410 420 430 440 450 511 513 515 520 530 540 700 850

UNION CARBIDE CORPORATION
CHEMICALS AND PLASTICS
INSTITUTE PLANT - LOCATION 512

DISABLING NO _____
OSHA NO _____

NAME: Epling, C P. JOB CLASSIFICATION: Painter Ins. SOC SEC NO. _____ PAYROLL NUMBER: 93645 158 HR SAL. (CIRCLE ONE)

DATE INJURY OCCURRED: DATE REPORTED: 26 Aug 80 TIME OF INJURY. (COMPLETE)

DESCRIPTION OF INJURY: Annual Asbestos Med Surv

RX:

CAUSE: 27 yr old

WORK RESTRICTIONS

SUPERVISOR WHEN INJURY OCCURRED:

IF SHIFT WORKER, CIRCLE SHIFT WORKING WHEN INJURY OCCURRED: A B C D

BUILDING NUMBER, AREA, OR UNIT WHERE INJURY OCCURRED:

CIRCLE COMPLEX IN WHICH EMPLOYEE WAS WORKING WHEN INJURY OCCURRED. 1 2 3 4 5 6 7 8

IF OTHER DEPARTMENT, CIRCLE LOCATION WHERE INJURY OCCURRED: OFFICE ENGINEERING DISTRIBUTION LABORATORY MAT'LS MGMT SHIFT UTILITY MECH.

CHECK YES OR NO IN PROVIDED SPACE WHETHER OR NOT SAFETY EQUIPMENT WAS BEING USED:

	YES	NO		YES	NO	RESPIRATOR:	YES	NO
SAFETY GLASSES	☐	☐	SAFETY SHOES	☐	☐	AIR LINE	☐	☐
COVERALL GOGGLES	☐	☐	INSTEP GUARD	☐	☐	SELF-CONTAINED	☐	☐
FACE SHIELD	☐	☐	PLASTIC, LEATHER OR			CHEMICAL CARTRIDGE	☐	☐
PVC CLOTHING	☐	☐	RUBBER GLOVES	☐	☐	DUST CARTRIDGE	☐	☐
COVERALLS	☐	☐	HARD HAT	☐	☐	EXPENDABLE	☐	☐
BOOTS	☐	☐	EAR PROTECTION	☐	☐	AIR CAPSULE OR SKA-PAK	☐	☐

SIGNATURE OF EMPLOYEE

ATTENDING NURSE: M. Luty

WITNESS

DISTRIBUTION OF REPORT: WHITE COPY IS FOR THE SAFETY DEPT.; YELLOW FOR DEPT. HEAD AND SHIFT SUPT

1ST AND 2ND COPIES ARE TO BE GIVEN TO THE INJURED EMPLOYEE BEFORE HE LEAVES THE MEDICAL DEPARTMENT HE WILL DELIVER THEM TO HIS SUPERVISOR WHO IS TO COMPLETE THE INJURY INVESTIGATION REPORT ON THE REVERSE

McBEE SYSTEMS M18019X

OPN./MAINT. COMPLEX: X 9 8 7 6 5 4 3 2 1

DEPARTMENT NUMBER: 938 010 391 355 342 327 308 229 227 22C 167 166 165 162 161 158 157 156 146 140 135 127 106 095 086 061 059 047 044 041 035 033 004 003

ACCIDENT TYPE (PER USAS Z 16.2 A1.4): 10 20 30 50 60 80 100 120 130 150 181 182 183 200 300 899 999

SOURCE OF INJURY: 1 4 5 6 7 9 13 15 17 19 20 22 23 25 26 28 30 41 44 46 49 50 54 56 57 58

SEX: M F

SHIFT: A B C D

MONTH: J F M A M J J A S O N D

UNSAFE ACT (USAS Z16.2 A1.8): 66 75 65 60 55 50 45 40 35 30 25 20 15 10 05

HAZARDOUS COND.: 0 1 2 3 4 5 6 7 9

UCC 017172

OSHA INJURY CATEGORY: A LWD | B O | MINOR NAI.

EMPLOYEE INJURY REPORT

NATURE OF INJURY: 1 ABRASION; 2 AMPUTATION; 3 BURN (TEMP); 4 BURN (CHEM); 5 CONTUSION; 6 DERMATITIS; 7 DSLOCATION; 8 ELEC SHOCK; 9 FRACTURE; 10 FREEZING; 11 HEARING LOSS; 12 HEAT STROKE; 13 HERNIA; 14 LACERATION; 15 POISONING; 16 PNEUMOCONIOSIS; 17 RADIATION; 18 SCRATCHES; 19 SPRAIN; 20 MULTIPLE

PART OF BODY AFFECTED (PER USAS Z 16.2 A1.2): 120; 130; 140; 150; 200; 311; 313; 315; 320; 330; 340; 410; 420; 430; 440; 450; 511; 513; 515; 520; 530; 540; 700; 850

UNION CARBIDE CORPORATION
CHEMICALS AND PLASTICS
INSTITUTE PLANT - LOCATION 512

DISABLING NO _____

OSHA NO _____

NAME: Hayes, J D

JOB CLASSIFICATION: Insulation Shop

SOC. SEC NO. _____

PAYROLL NUMBER: 93555 4601 (HR) SAL (CIRCLE ONE)

DATE INJURY OCCURRED:

DATE REPORTED: 27 Aug 80

TIME OF INJURY: (COMPLETE)

DESCRIPTION OF INJURY: Cement Asbestos Mud Sure

RX:

CAUSE: 15 yrs exp.

WORK RESTRICTIONS

SUPERVISOR WHEN INJURY OCCURRED:

IF SHIFT WORKER, CIRCLE SHIFT WORKING WHEN INJURY OCCURRED: A B C D

BUILDING NUMBER, AREA, OR UNIT WHERE INJURY OCCURRED:

CIRCLE COMPLEX IN WHICH EMPLOYEE WAS WORKING WHEN INJURY OCCURRED: 1 2 3 4 5 6 7 8

IF OTHER DEPARTMENT, CIRCLE LOCATION WHERE INJURY OCCURRED: OFFICE ENGINEERING DISTRIBUTION LABORATORY MAT'LS MGMT SHIFT UTILITY MECH.

CHECK YES OR NO IN PROVIDED SPACE WHETHER OR NOT SAFETY EQUIPMENT WAS BEING USED:

	YES	NO		YES	NO
SAFETY GLASSES	☐	☐	SAFETY SHOES	☐	☐
COVERALL GOGGLES	☐	☐	INSTEP GUARD	☐	☐
FACE SHIELD	☐	☐	PLASTIC, LEATHER OR RUBBER GLOVES	☐	☐
PVC CLOTHING	☐	☐	HARD HAT	☐	☐
COVERALLS	☐	☐	EAR PROTECTION	☐	☐
BOOTS	☐	☐			

RESPIRATOR:

	YES	NO
AIR LINE	☐	☐
SELF-CONTAINED	☐	☐
CHEMICAL CARTRIDGE	☐	☐
DUST CARTRIDGE	☐	☐
EXPENDABLE	☐	☐
AIR CAPSULE OR SKA-PAK	☐	☐

SIGNATURE OF EMPLOYEE

ATTENDING NURSE: B. Pitt

WITNESS

DISTRIBUTION OF REPORT: WHITE COPY IS FOR THE SAFETY DEPT.; YELLOW FOR DEPT. HEAD AND SHIFT SUPT

1ST AND 2ND COPIES ARE TO BE GIVEN TO THE INJURED EMPLOYEE BEFORE HE LEAVES THE MEDICAL DEPARTMENT HE WILL DELIVER THEM TO HIS SUPERVISOR WHO IS TO COMPLETE THE INJURY INVESTIGATION REPORT ON THE REVERSE

McBEE SYSTEMS M18019X

OPN./MAINT. COMPLEX: X; 9 8 7 6 5 4 3 2 1

DEPARTMENT NUMBER: 938; 010; 391; 355; 342; 327; 308; 229; 227; 220; 167; 166; 165; 162; 161; 158; 157; 156; 146; 140; 135; 127; 106; 095; 086; 061; 059; 047; 044; 041; 035; 033; 004; 003

ACCIDENT TYPE (PER USAS Z 16.2 A1.4): 10; 20; 30; 50; 60; 80; 100; 120; 130; 150; 181; 182; 183; 200; 300; 899; 999

SOURCE OF INJURY: 1 4 5 6 7 9 13 15 17 19 20 22 23 25 26 28 30 41 44 46 49 50 54 56 57 58

SEX: M F

SHIFT: A B C D

MONTH: J F M A M J J A S O N D

UNSAFE ACT (USAS Z16.2 A1.8): 05 10 15 20 25 30 35 40 45 50 55 60 65 75 66

HAZARDOUS COND.: 0 1 2 3 4 5 6 7 8 9

UCC 017173

EMPLOYEE INJURY REPORT

OSHA INJURY CATEGORY: A LWD | B | O | MINOR | NAI.

NATURE OF INJURY: 1 ABRASION; 2 AMPUTATION; 3 BURN (TEMP); 4 BURN (CHEM); 5 CONTUSION; 6 DERMATITIS; 7 DISLOCATION; 8 ELEC SHOCK; 9 FRACTURE; 10 FREEZING; 11 HEARING LOSS; 12 HEAT STROKE; 13 HERNIA; 14 LACERATION; 15 POISONING; 16 PNEUMOCONIOSIS; 17 RADIATION; 18 SCRATCHES; 19 SPRAIN; 20 MULTIPLE

PART OF BODY AFFECTED (PER USAS Z 16.2 A1.2): 120; 130; 140; 150; 200; 311; 313; 315; 320; 330; 340; 410; 420; 430; 440; 450; 511; 513; 515; 520; 530; 540; 700; 850

ACCIDENT TYPE (PER USAS Z 16.2 A1.4): 10; 20; 30; 50; 60; 80; 100; 120; 130; 150; 181; 182; 183; 200; 300; 899; 999

UNION CARBIDE CORPORATION
CHEMICALS AND PLASTICS
INSTITUTE PLANT - LOCATION 512

DISABLING NO _____
OSHA NO _____

NAME: Johnson, W.A. JOB CLASSIFICATION Mechanic

SOC SEC. NO _____

PAYROLL NUMBER: 45663 4256 (HR) SAL. (CIRCLE ONE)

DATE INJURY OCCURRED: DATE REPORTED: 27 Aug 80

TIME OF INJURY: (COMPLETE)

DESCRIPTION OF INJURY: Annual Asbestos Med. Surv

RX:

CAUSE: 11 yrs. exposure

WORK RESTRICTIONS

SUPERVISOR WHEN INJURY OCCURRED:

IF SHIFT WORKER. CIRCLE SHIFT WORKING WHEN INJURY OCCURRED: A B C D

BUILDING NUMBER, AREA, OR UNIT WHERE INJURY OCCURRED:

CIRCLE COMPLEX IN WHICH EMPLOYEE WAS WORKING WHEN INJURY OCCURRED. 1 2 3 4 5 6 7 8

IF OTHER DEPARTMENT. CIRCLE LOCATION WHERE INJURY OCCURRED: OFFICE ENGINEERING DISTRIBUTION LABORATORY MAT'LS MGMT SHIFT UTILITY MECH.

CHECK YES OR NO IN PROVIDED SPACE WHETHER OR NOT SAFETY EQUIPMENT WAS BEING USED.

	YES	NO		YES	NO	RESPIRATOR:	YES	NO
SAFETY GLASSES	☐	☐	SAFETY SHOES	☐	☐	AIR LINE	☐	☐
COVERALL GOGGLES	☐	☐	INSTEP GUARD	☐	☐	SELF-CONTAINED	☐	☐
FACE SHIELD	☐	☐	PLASTIC, LEATHER OR			CHEMICAL CARTRIDGE	☐	☐
PVC CLOTHING	☐	☐	RUBBER GLOVES	☐	☐	DUST. CARTRIDGE	☐	☐
COVERALLS	☐	☐	HARD HAT	☐	☐	EXPENDABLE	☐	☐
BOOTS	☐	☐	EAR PROTECTION	☐	☐	AIR CAPSULE OR SKA-PAK	☐	☐

SIGNATURE OF EMPLOYEE

ATTENDING NURSE M. Petty

WITNESS

DISTRIBUTION OF REPORT: WHITE COPY IS FOR THE SAFETY DEPT; YELLOW FOR DEPT HEAD AND SHIFT SUPT

1ST AND 2ND COPIES ARE TO BE GIVEN TO THE INJURED EMPLOYEE BEFORE HE LEAVES THE MEDICAL DEPARTMENT. HE WILL DELIVER THEM TO HIS SUPERVISOR WHO IS TO COMPLETE THE INJURY INVESTIGATION REPORT ON THE REVERSE

OPN./MAINT. COMPLEX: 9 8 7 6 5 4 3 2 1

DEPARTMENT NUMBER: 938; 010; 391; 355; 342; 327; 308; 229; 227; 220; 167; 166; 165; 162; 161; 158; 157; 156; 146; 140; 135; 127; 106; 095; 086; 061; 059; 047; 044; 041; 035; 033; 003A; 003

SOURCE OF INJURY: 1 4 5 6 7 9 13 15 17 19 20 22 23 25 26 28 30 41 44 46 49 50 54 56 57 58

SEX: M F

SHIFT: A B C D

MONTH: J F M A M J J A S O N D

UNSAFE ACT (USAS Z16.2 A1.8): 66 75 65 60 55 50 45 40 35 30 25 20 15 10 05

HAZARDOUS COND.: 9 7 6 5 4 3 2 1 0

UCC 017174

UCC 017175

F

A LWD B O MINOR NAI.

OSHA INJURY CATEGORY

EMPLOYEE INJURY REPORT

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20
ABRASION	AMPUTATION	BURN (TEMP)	BURN (CHEM)	CONTUSION	DERMATITIS	DISLOCATION	ELEC SHOCK	FRACTURE	FREEZING	HEARING LOSS	HEAT STROKE	HERNIA	LACERATION	POISONING	PNEUMOCONIOSIS	RADIATION	SCRATCHES	SPRAIN	MULTIPLE

NATURE OF INJURY

120	130	140	150	200	311	313	315	320	330	340	410	420	430	440	450	511	513	515	520	530	540	700	850

PART OF BODY AFFECTED (PER USAS Z 16.2 A1.2)

UNION CARBIDE CORPORATION
CHEMICALS AND PLASTICS
INSTITUTE PLANT - LOCATION 512

DISABLING NO. _____
OSHA NO. _____

NAME: Landers, L W. JOB CLASSIFICATION: Insulator

SOC. SEC. NO. _____

PAYROLL NUMBER: 93642-1211 (HR) SAL.
(CIRCLE ONE)

TIME OF INJURY: (COMPLETE)

DATE INJURY OCCURRED: DATE REPORTED: 27 Aug 80

DESCRIPTION OF INJURY: Contact Caustic Med Sweet.

RX:

CAUSE: 18 yrs exposure

WORK RESTRICTIONS

SUPERVISOR WHEN INJURY OCCURRED:

IF SHIFT WORKER, CIRCLE SHIFT WORKING WHEN INJURY OCCURRED: A B C D

BUILDING NUMBER, AREA, OR UNIT WHERE INJURY OCCURRED:

CIRCLE COMPLEX IN WHICH EMPLOYEE WAS WORKING WHEN INJURY OCCURRED: 1 2 3 4 5 6 7 8

IF OTHER DEPARTMENT, CIRCLE LOCATION WHERE INJURY OCCURRED: OFFICE ENGINEERING DISTRIBUTION LABORATORY MAT'LS MGMT SHIFT UTILITY MECH.

CHECK YES OR NO IN PROVIDED SPACE WHETHER OR NOT SAFETY EQUIPMENT WAS BEING USED:

	YES	NO		YES	NO	RESPIRATOR	YES	NO
SAFETY GLASSES	☐	☐	SAFETY SHOES	☐	☐	AIR LINE	☐	☐
COVERALL GOGGLES	☐	☐	INSTEP GUARD	☐	☐	SELF-CONTAINED	☐	☐
FACE SHIELD	☐	☐	PLASTIC, LEATHER OR			CHEMICAL CARTRIDGE	☐	☐
PVC CLOTHING	☐	☐	RUBBER GLOVES	☐	☐	DUST CARTRIDGE	☐	☐
COVERALLS	☐	☐	HARD HAT	☐	☐	EXPENDABLE	☐	☐
BOOTS	☐	☐	EAR PROTECTION	☐	☐	AIR CAPSULE OR SKA-PAK	☐	☐

SIGNATURE OF EMPLOYEE

ATTENDING NURSE

WITNESS

DISTRIBUTION OF REPORT: WHITE COPY IS FOR THE SAFETY DEPT.; YELLOW FOR DEPT. HEAD AND SHIFT SUPT.
1ST AND 2ND COPIES ARE TO BE GIVEN TO THE INJURED EMPLOYEE BEFORE HE LEAVES THE MEDICAL DEPARTMENT. HE WILL DELIVER THEM TO HIS SUPERVISOR WHO IS TO COMPLETE THE INJURY INVESTIGATION REPORT ON THE REVERSE

MCBEE ® SYSTEMS M180198

OPN./MAINT. COMPLEX: X

DEPARTMENT NUMBER

9	8	7	6	5	4	3	2	1
			938	010	391		355	342

327	308	229		227	22C	167	166	165	162	161	158	157	156	146	140	135	127	106	095	086	061	059	047	044	041	035	033

ACCIDENT TYPE (PER USAS Z 16.2 A1.4)

10 20 30 50 60 80 100 120 130 150 181 182 183 200 300 899 999

SOURCE OF INJURY

1 4 5 6 7 9 13 15 17 19 20 22 23 25 26 28 30 41 44 46 49 50 54 56 57 58

SEX: M F

SHIFT: A B C D

MONTH: J F M A M J J A S O N D

UNSAFE ACT (USAS Z16.2 A1.8): 66 75 65 60 55 50 45 40 35 30 25 20 15 10 50

HAZARDOUS COND.: 9 8 7 6 5 4 3 2 1 0

UCC 017176

F

OSHA INJURY CATEGORY: A LWD | B O | MINOR NAI.

EMPLOYEE INJURY REPORT

NATURE OF INJURY: 1 ABRASION | 2 AMPUTATION | 3 BURN (TEMP) | 4 BURN (CHEM) | 5 CONTUSION | 6 DERMATITIS | 7 DISLOCATION | 8 ELEC SHOCK | 9 FRACTURE | 10 FREEZING | 11 HEARING LOSS | 12 HEAT STROKE | 13 HERNIA | 14 LACERATION | 15 POISONING | 16 PNEUMOCONIOSIS | 17 RADIATION | 18 SCRATCHES | 19 SPRAIN | 20 MULTIPLE

PART OF BODY AFFECTED (PER USAS Z 16.2 A1.2): 120 | 130 | 140 | 150 | 200 | 311 | 313 | 315 | 320 | 330 | 340 | 410 | 420 | 430 | 440 | 450 | 511 | 513 | 515 | 520 | 530 | 540 | 700 | 850

UNION CARBIDE CORPORATION
CHEMICALS AND PLASTICS
INSTITUTE PLANT - LOCATION 512

DISABLING NO _____
OSHA NO _____

NAME: Mathews WA JOB CLASSIFICATION Painter

SOC SEC NO _____ – _____ – _____

PAYROLL NUMBER 03645 4435 (HR.) SAL. (CIRCLE ONE)

DATE INJURY OCCURRED: _____ DATE REPORTED: 27 Aug 80

TIME OF INJURY (COMPLETE)

DESCRIPTION OF INJURY Annual Asbestos Med Surv

RX:

CAUSE: 20 yrs exp.

WORK RESTRICTIONS

SUPERVISOR WHEN INJURY OCCURRED:

IF SHIFT WORKER, CIRCLE SHIFT WORKING WHEN INJURY OCCURRED: A B C D

BUILDING NUMBER, AREA, OR UNIT WHERE INJURY OCCURRED:

CIRCLE COMPLEX IN WHICH EMPLOYEE WAS WORKING WHEN INJURY OCCURRED: 1 2 3 4 5 6 7 8

IF OTHER DEPARTMENT, CIRCLE LOCATION WHERE INJURY OCCURRED: OFFICE ENGINEERING DISTRIBUTION LABORATORY MAT'LS MGMT SHIFT UTILITY MECH.

CHECK YES OR NO IN PROVIDED SPACE WHETHER OR NOT SAFETY EQUIPMENT WAS BEING USED:

	YES	NO		YES	NO	RESPIRATOR:	YES	NO
SAFETY GLASSES	☐	☐	SAFETY SHOES	☐	☐	AIR LINE	☐	☐
COVERALL GOGGLES	☐	☐	INSTEP GUARD	☐	☐	SELF-CONTAINED	☐	☐
FACE SHIELD	☐	☐				CHEMICAL CARTRIDGE	☐	☐
PVC CLOTHING	☐	☐	PLASTIC, LEATHER OR RUBBER GLOVES	☐	☐	DUST CARTRIDGE	☐	☐
COVERALLS	☐	☐	HARD HAT	☐	☐	EXPENDABLE	☐	☐
BOOTS	☐	☐	EAR PROTECTION	☐	☐	AIR CAPSULE OR SKA-PAK	☐	☐

SIGNATURE OF EMPLOYEE

ATTENDING NURSE M. Petty

WITNESS

DISTRIBUTION OF REPORT: WHITE COPY IS FOR THE SAFETY DEPT., YELLOW FOR DEPT. HEAD AND SHIFT SUPT

1ST AND 2ND COPIES ARE TO BE GIVEN TO THE INJURED EMPLOYEE BEFORE HE LEAVES THE MEDICAL DEPARTMENT. HE WILL DELIVER THEM TO HIS SUPERVISOR WHO IS TO COMPLETE THE INJURY INVESTIGATION REPORT ON THE REVERSE

OPN./MAINT. COMPLEX: X | 9 8 7 6 5 4 3 2 1

DEPARTMENT NUMBER: 938 | 010 | 391 | 355 | 342 | 327 | 308 | 229 | 227 | 220 | 167 | 166 | 165 | 162 | 161 | 158 | 157 | 156 | 146 | 140 | 135 | 127 | 106 | 095 | 086 | 061 | 059 | 047 | 044 | 041 | 035 | 033 | 004 | 003

MONTH: J F M A M J J A S O N D

UNSAFE ACT (USAS Z16.2 A1.8): 66 | 75 | 65 | 60 | 55 | 50 | 45 | 40 | 35 | 30 | 25 | 20 | 15 | 10 | 05

HAZARDOUS COND.: 9 8 7 6 5 4 3 2 1 0

ACCIDENT TYPE (PER USAS Z 16.2 A1.4): 10 | 20 | 30 | 50 | 60 | 80 | 100 | 120 | 130 | 150 | 181 | 182 | 183 | 200 | 300 | 899 | 999

SOURCE OF INJURY: 1 4 5 6 7 9 13 15 17 19 20 22 23 | 25 26 28 30 41 44 46 49 50 54 56 57 58

SEX: M F

SHIFT: A B C D

UNION CARBIDE CORPORATION
CHEMICALS AND PLASTICS
INSTITUTE PLANT - LOCATION 512

EMPLOYEE INJURY REPORT

DISABLING NO ______
OSHA NO ______

OSHA INJURY CATEGORY: A B LWD | O | MINOR | NAI.

NATURE OF INJURY: 1 ABRASION | 2 AMPUTATION | 3 BURN (TEMP) | 4 BURN (CHEM) | 5 CONTUSION | 6 DERMATITIS | 7 DISLOCATION | 8 ELEC SHOCK | 9 FRACTURE | 10 FREEZING | 11 HEARING LOSS | 12 HEAT STROKE | 13 HERNIA | 14 LACERATION | 15 POISONING | 16 PNEUMOCONIOSIS | 17 RADIATION | 18 SCRATCHES | 19 SPRAIN | 20 MULTIPLE

PART OF BODY AFFECTED (PER USAS Z 16.2 A1.2): 120 130 140 150 200 311 313 315 320 330 340 410 420 430 440 450 511 513 515 520 530 540 700 850

ACCIDENT TYPE (PER USAS Z 16.2 A1.4): 10 20 30 50 60 80 100 120 130 150 181 182 183 200 300 899 999

MONTH: J F M A M J J A S O N D

NAME: Mitchell L L | JOB CLASSIFICATION: Insulator Shop | SOC SEC NO. [ ] [ ] [ ] – [ ] [ ] – [ ] [ ] [ ] [ ]

PAYROLL NUMBER (COMPLETE): 95255 .527 | HR. (circled) SAL. (CIRCLE ONE)

DATE INJURY OCCURRED: | DATE REPORTED: 27 Aug 80 | TIME OF INJURY:

DESCRIPTION OF INJURY: Annual Asbestos Med Surv

RX:

CAUSE: 28 yrs exp.

WORK RESTRICTIONS:

SUPERVISOR WHEN INJURY OCCURRED:

IF SHIFT WORKER, CIRCLE SHIFT WORKING WHEN INJURY OCCURRED: A B C D

BUILDING NUMBER, AREA, OR UNIT WHERE INJURY OCCURRED:

CIRCLE COMPLEX IN WHICH EMPLOYEE WAS WORKING WHEN INJURY OCCURRED: 1 2 3 4 5 6 7 8

IF OTHER DEPARTMENT, CIRCLE LOCATION WHERE INJURY OCCURRED: OFFICE ENGINEERING DISTRIBUTION LABORATORY MAT'LS MGMT SHIFT UTILITY MECH.

CHECK YES OR NO IN PROVIDED SPACE WHETHER OR NOT SAFETY EQUIPMENT WAS BEING USED:

	YES	NO		YES	NO	RESPIRATOR:	YES	NO
SAFETY GLASSES	☐	☐	SAFETY SHOES	☐	☐	AIR LINE	☐	☐
COVERALL GOGGLES	☐	☐	INSTEP GUARD	☐	☐	SELF-CONTAINED	☐	☐
FACE SHIELD	☐	☐				CHEMICAL CARTRIDGE	☐	☐
PVC CLOTHING	☐	☐	PLASTIC, LEATHER OR RUBBER GLOVES	☐	☐	DUST. CARTRIDGE	☐	☐
COVERALLS	☐	☐	HARD HAT	☐	☐	EXPENDABLE	☐	☐
BOOTS	☐	☐	EAR PROTECTION	☐	☐	AIR CAPSULE OR SKA-PAK	☐	☐

SIGNATURE OF EMPLOYEE ______ | ATTENDING NURSE [signature] | WITNESS ______

DISTRIBUTION OF REPORT: WHITE COPY IS FOR THE SAFETY DEPT; YELLOW FOR DEPT. HEAD AND SHIFT SUPT
1ST AND 2ND COPIES ARE TO BE GIVEN TO THE INJURED EMPLOYEE BEFORE HE LEAVES THE MEDICAL DEPARTMENT. HE WILL DELIVER THEM TO HIS SUPERVISOR WHO IS TO COMPLETE THE INJURY INVESTIGATION REPORT ON THE REVERSE.

MCBEE SYSTEMS M18019X

OPN./MAINT. COMPLEX: 9 8 7 6 5 4 3 2 1

DEPARTMENT NUMBER: 938 010 391 355 342 327 308 229 227 220 167 166 165 162 161 158 157 156 146 140 135 127 106 095 086 061 059 047 044 041 035 033 004 003

SOURCE OF INJURY: 1 4 5 6 7 9 13 15 17 19 20 22 23 / 25 26 28 30 41 44 46 49 50 54 56 57 58

SEX: M F | SHIFT: A B C D

UNSAFE ACT (USAS Z16.2 A1.8): 99 75 65 60 55 50 45 40 35 30 25 20 15 10 05

HAZARDOUS COND.: X 0 1 2 3 4 5 6 7 9

UCC 017177

EMPLOYEE INJURY REPORT

OSHA INJURY CATEGORY: F | A LWD | B | O | MINOR | NAI

NATURE OF INJURY: 1 ABRASION; 2 AMPUTATION; 3 BURN (TEMP); 4 BURN (CHEM); 5 CONTUSION; 6 DERMATITIS; 7 DISLOCATION; 8 ELEC SHOCK; 9 FRACTURE; 10 FREEZING; 11 HEARING LOSS; 12 HEAT STROKE; 13 HERNIA; 14 LACERATION; 15 POISONING; 16 PNEUMOCONIOSIS; 17 RADIATION; 18 SCRATCHES; 19 SPRAIN; 20 MULTIPLE

PART OF BODY AFFECTED (PER USAS Z 16.2 A1.2): 120 130 140 150 200 311 313 315 320 330 340 410 420 430 440 450 511 513 515 520 530 540 700 850

ACCIDENT TYPE (PER USAS Z 16.2 A1.4): 10 20 30 50 60 80 100 120 130 150 181 182 183 200 300 899 999

SOURCE OF INJURY

UNION CARBIDE CORPORATION
CHEMICALS AND PLASTICS
INSTITUTE PLANT - LOCATION 512

DISABLING NO. _____
OSHA NO. _____

NAME: Roan, C L JOB CLASSIFICATION: Painter

SOC SEC NO. ___-___-____

PAYROLL NUMBER: 9564J 4431 (HR.) SAL. (CIRCLE ONE)

DATE INJURY OCCURRED: TIME OF INJURY (COMPLETE): DATE REPORTED: 27 Aug 80

DESCRIPTION OF INJURY: Cervical Radiculitis Med Surv.

RX:

CAUSE: Heavy Lift

WORK RESTRICTIONS

SUPERVISOR WHEN INJURY OCCURRED:

IF SHIFT WORKER, CIRCLE SHIFT WORKING WHEN INJURY OCCURRED: A B C D

BUILDING NUMBER, AREA, OR UNIT WHERE INJURY OCCURRED:

CIRCLE COMPLEX IN WHICH EMPLOYEE WAS WORKING WHEN INJURY OCCURRED: 1 2 3 4 5 6 7 8

IF OTHER DEPARTMENT, CIRCLE LOCATION WHERE INJURY OCCURRED: OFFICE ENGINEERING DISTRIBUTION LABORATORY MAT'LS MGMT SHIFT UTILITY MECH.

CHECK YES OR NO IN PROVIDED SPACE WHETHER OR NOT SAFETY EQUIPMENT WAS BEING USED:

	YES	NO		YES	NO	RESPIRATOR:	YES	NO
SAFETY GLASSES	☐	☐	SAFETY SHOES	☐	☐	AIR LINE	☐	☐
COVERALL GOGGLES	☐	☐	INSTEP GUARD	☐	☐	SELF-CONTAINED	☐	☐
FACE SHIELD	☐	☐				CHEMICAL CARTRIDGE	☐	☐
PVC CLOTHING	☐	☐	PLASTIC, LEATHER OR RUBBER GLOVES	☐	☐	DUST: CARTRIDGE	☐	☐
COVERALLS	☐	☐	HARD HAT	☐	☐	EXPENDABLE	☐	☐
BOOTS	☐	☐	EAR PROTECTION	☐	☐	AIR CAPSULE OR SKA-PAK	☐	☐

SIGNATURE OF EMPLOYEE

ATTENDING NURSE: M Petty

WITNESS

DISTRIBUTION OF REPORT: WHITE COPY IS FOR THE SAFETY DEPT.; YELLOW FOR DEPT HEAD AND SHIFT SUPT

1ST AND 2ND COPIES ARE TO BE GIVEN TO THE INJURED EMPLOYEE BEFORE HE LEAVES THE MEDICAL DEPARTMENT HE WILL DELIVER THEM TO HIS SUPERVISOR WHO IS TO COMPLETE THE INJURY INVESTIGATION REPORT ON THE REVERSE

McGEE SYSTEMS M180I9X

SEX: M F

SHIFT: A B C D

MONTH: J F M A M J J A S O N D

UNSAFE ACT (USAS Z16.2 A1.8): 66 75 65 60 55 50 45 40 35 30 25 20 15 10 05

HAZARDOUS COND.: 0 1 2 3 4 5 6 7 8 9

UCC 017178

OPN./MAINT. COMPLEX: X 9 8 7 6 5 4 3 2 1

DEPARTMENT NUMBER: 938 010 391 355 342 327 308 229 227 220 167 166 165 162 161 158 157 156 146 140 135 127 106 095 086 061 059 047 044 041 035 033 004 003

EMPLOYEE INJURY REPORT

OSHA INJURY CATEGORY: A LWD · B O · MINOR NAI.

NATURE OF INJURY: 1 ABRASION · 2 AMPUTATION · 3 BURN (TEMP) · 4 BURN (CHEM) · 5 CONTUSION · 6 DERMATITIS · 7 DISLOCATION · 8 ELEC SHOCK · 9 FRACTURE · 10 FREEZING · 11 HEARING LOSS · 12 HEAT STROKE · 13 HERNIA · 14 LACERATION · 15 POISONING · 16 PNEUMOCONIOSIS · 17 RADIATION · 18 SCRATCHES · 19 SPRAIN · 20 MULTIPLE

PART OF BODY AFFECTED (PER USAS Z 16.2 A1.2): 120 · 130 · 140 · 150 · 200 · 311 · 313 · 315 · 320 · 330 · 340 · 410 · 420 · 430 · 440 · 450 · 511 · 513 · 515 · 520 · 530 · 540 · 700 · 850

UNION CARBIDE CORPORATION
CHEMICALS AND PLASTICS
INSTITUTE PLANT - LOCATION 512

DISABLING NO _____
OSHA NO _____

NAME: Shaffer, L.R. JOB CLASSIFICATION Insulator

SOC SEC NO. ___ — ___ — ____

PAYROLL NUMBER 9364 3117 (HR) SAL. (CIRCLE ONE)

DATE INJURY OCCURRED: DATE REPORTED: 27 Aug 80

TIME OF INJURY (COMPLETE)

DESCRIPTION OF INJURY: Accrued Asbestos Mesothelioma

RX:

CAUSE: 18 yrs exp.

WORK RESTRICTIONS

SUPERVISOR WHEN INJURY OCCURRED:

IF SHIFT WORKER, CIRCLE SHIFT WORKING WHEN INJURY OCCURRED: A B C D

BUILDING NUMBER, AREA, OR UNIT WHERE INJURY OCCURRED:

CIRCLE COMPLEX IN WHICH EMPLOYEE WAS WORKING WHEN INJURY OCCURRED: 1 2 3 4 5 6 7 8

IF OTHER DEPARTMENT, CIRCLE LOCATION WHERE INJURY OCCURRED: OFFICE ENGINEERING DISTRIBUTION LABORATORY MAT'LS MGMT SHIFT UTILITY MECH

CHECK YES OR NO IN PROVIDED SPACE WHETHER OR NOT SAFETY EQUIPMENT WAS BEING USED:

	YES	NO		YES	NO	RESPIRATOR:	YES	NO
SAFETY GLASSES	☐	☐	SAFETY SHOES	☐	☐	AIR LINE	☐	☐
COVERALL GOGGLES	☐	☐	INSTEP GUARD	☐	☐	SELF-CONTAINED	☐	☐
FACE SHIELD	☐	☐				CHEMICAL CARTRIDGE	☐	☐
PVC CLOTHING	☐	☐	PLASTIC, LEATHER OR RUBBER GLOVES	☐	☐	DUST CARTRIDGE	☐	☐
COVERALLS	☐	☐	HARD HAT	☐	☐	EXPENDABLE	☐	☐
BOOTS	☐	☐	EAR PROTECTION	☐	☐	AIR CAPSULE OR SKA-PAK	☐	☐

SIGNATURE OF EMPLOYEE

ATTENDING NURSE M. Pitt

WITNESS

DISTRIBUTION OF REPORT: WHITE COPY IS FOR THE SAFETY DEPT.; YELLOW FOR DEPT. HEAD AND SHIFT SUPT

1ST AND 2ND COPIES ARE TO BE GIVEN TO THE INJURED EMPLOYEE BEFORE HE LEAVES THE MEDICAL DEPARTMENT HE WILL DELIVER THEM TO HIS SUPERVISOR WHO IS TO COMPLETE THE INJURY INVESTIGATION REPORT ON THE REVERSE

McGEE SYSTEMS M18019X

OPN./MAINT. COMPLEX: X

DEPARTMENT NUMBER: 9 8 7 6 5 4 3 2 1 — 938 · 010 · 391 · 355 · 342 · 327 · 308 · 229 · 227 · 220 · 167 · 165 · 163 · 162 · 161 · 158 · 157 · 156 · 146 · 140 · 135 · 127 · 105 · 095 · 086 · 061 · 059 · 047 · 044 · 041 · 035 · 033 · 001 · 003

ACCIDENT TYPE (PER USAS Z 16.2 A1.4): 10 · 20 · 30 · 50 · 60 · 80 · 100 · 120 · 130 · 150 · 181 · 182 · 183 · 200 · 300 · 899 · 999

SOURCE OF INJURY: 1 4 5 6 7 9 13 15 17 19 20 22 23 25 26 28 30 41 44 46 49 50 54 56 57 58

SEX: M F

SHIFT: A B C D

MONTH: J F M A M J J A S O N D

UNSAFE ACT (USAS Z16.2 A1.8): 00 05 10 15 20 25 30 35 40 45 50 55 60 65 75 66

HAZARDOUS COND.: 0 1 2 3 4 5 6 7 8 9

UCC 01779

UCC 01780

EMPLOYEE INJURY REPORT

OSHA INJURY CATEGORY: A LWD | B MINOR | O NAI.

NATURE OF INJURY: 1 ABRASION | 2 AMPUTATION | 3 BURN (TEMP) | 4 BURN (CHEM) | 5 CONTUSION | 6 DERMATITIS | 7 DISLOCATION | 8 ELEC SHOCK | 9 FRACTURE | 10 FREEZING | 11 HEARING LOSS | 12 HEAT STROKE | 13 HERNIA | 14 LACERATION | 15 POISONING | 16 PNEUMOCONIOSIS | 17 RADIATION | 18 SCRATCHES | 19 SPRAIN | 20 MULTIPLE

PART OF BODY AFFECTED (PER USAS Z 16.2 A1.2): 120 | 130 | 140 | 150 | 200 | 311 | 313 | 315 | 320 | 330 | 340 | 410 | 420 | 430 | 440 | 450 | 511 | 513 | 515 | 520 | 530 | 540 | 700 | 850

UNION CARBIDE CORPORATION
CHEMICALS AND PLASTICS
INSTITUTE PLANT - LOCATION 512

DISABLING NO _____
OSHA NO _____

NAME: Hamblin D C JOB CLASSIFICATION Insulator SOC. SEC. NO _____

PAYROLL NUMBER 8242 1218 (HR) SAL (CIRCLE ONE)

DATE INJURY OCCURRED: _____ DATE REPORTED: 27 Aug 80 TIME OF INJURY. (COMPLETE)

DESCRIPTION OF INJURY: Chronic Asbestos Med Surv

RX:

CAUSE: 30 yrs exposure

WORK RESTRICTIONS

SUPERVISOR WHEN INJURY OCCURRED:

IF SHIFT WORKER, CIRCLE SHIFT WORKING WHEN INJURY OCCURRED: A B C D

BUILDING NUMBER, AREA, OR UNIT WHERE INJURY OCCURRED:

CIRCLE COMPLEX IN WHICH EMPLOYEE WAS WORKING WHEN INJURY OCCURRED. 1 2 3 4 5 6 7 8

IF OTHER DEPARTMENT, CIRCLE LOCATION WHERE INJURY OCCURRED: OFFICE ENGINEERING DISTRIBUTION LABORATORY MAT'LS MGMT SHIFT UTILITY MECH

CHECK YES OR NO IN PROVIDED SPACE WHETHER OR NOT SAFETY EQUIPMENT WAS BEING USED:

	YES	NO		YES	NO	RESPIRATOR.	YES	NO
SAFETY GLASSES	☐	☐	SAFETY SHOES	☐	☐	AIR LINE	☐	☐
COVERALL GOGGLES	☐	☐	INSTEP GUARD	☐	☐	SELF-CONTAINED	☐	☐
FACE SHIELD	☐	☐	PLASTIC, LEATHER OR			CHEMICAL CARTRIDGE	☐	☐
PVC CLOTHING	☐	☐	RUBBER GLOVES	☐	☐	DUST. CARTRIDGE	☐	☐
COVERALLS	☐	☐	HARD HAT	☐	☐	EXPENDABLE	☐	☐
BOOTS	☐	☐	EAR PROTECTION	☐	☐	AIR CAPSULE OR SKA-PAK	☐	☐

SIGNATURE OF EMPLOYEE

ATTENDING NURSE D Petty

WITNESS

DISTRIBUTION OF REPORT: WHITE COPY IS FOR THE SAFETY DEPT.; YELLOW FOR DEPT. HEAD AND SHIFT SUPT

1ST AND 2ND COPIES ARE TO BE GIVEN TO THE INJURED EMPLOYEE BEFORE HE LEAVES THE MEDICAL DEPARTMENT HE WILL DELIVER THEM TO HIS SUPERVISOR WHO IS TO COMPLETE THE INJURY INVESTIGATION REPORT ON THE REVERSE.

MCDEE SYSTEMS M18019X

OPN./MAINT. COMPLEX: X | 9 8 7 6 5 4 3 2 1

DEPARTMENT NUMBER: 938 | 010 | 391 | 355 | 342 | 327 | 308 | 223 | 227 | 220 | 167 | 166 | 165 | 162 | 161 | 158 | 157 | 156 | 146 | 140 | 135 | 127 | 106 | 095 | 086 | 061 | 059 | 047 | 044 | 041 | 035 | 033 | 001 | 003

MONTH: F | M A M J J A S O N D

UNSAFE ACT (USAS Z16.2 A1.8): 66 | 57 | 65 | 60 | 55 | 50 | 45 | 40 | 35 | 30 | 25 | 20 | 15 | 10 | 05

HAZARDOUS COND.: 9 | 7 | 6 | 5 | 4 | 3 | 2 | 1 | 0

ACCIDENT TYPE (PER USAS Z 16.2 A1.4): 10 | 20 | 30 | 50 | 60 | 80 | 100 | 120 | 130 | 150 | 181 | 182 | 183 | 200 | 300 | 899 | 999

SOURCE OF INJURY: 1 4 5 6 7 9 13 15 17 19 20 22 23 | 25 26 28 30 41 44 46 49 50 54 56 57 58

SEX: M F

SHIFT: A B C D

UCC 01781

F

OSHA INJURY CATEGORY: A LWD | B O MINOR NAI.

EMPLOYEE INJURY REPORT

NATURE OF INJURY: 1 ABRASION | 2 AMPUTATION | 3 BURN (TEMP) | 4 BURN (CHEM) | 5 CONTUSION | 6 DERMATITIS | 7 DISLOCATION | 8 ELEC. SHOCK | 9 FRACTURE | 10 FREEZING | 11 HEARING LOSS | 12 HEAT STROKE | 13 HERNIA | 14 LACERATION | 15 POISONING | 16 PNEUMOCONIOSIS | 17 RADIATION | 18 SCRATCHES | 19 SPRAIN | 20 MULTIPLE

PART OF BODY AFFECTED (PER USAS Z 16.2 A1.2): 120 | 130 | 140 | 150 | 200 | 311 | 313 | 315 | 320 | 330 | 340 | 410 | 420 | 430 | 440 | 450 | 511 | 513 | 515 | 520 | 530 | 540 | 700 | 850

UNION CARBIDE CORPORATION
CHEMICALS AND PLASTICS
INSTITUTE PLANT - LOCATION 512

DISABLING NO _____
OSHA NO _____

NAME: Smith, W C JOB CLASSIFICATION Instructor SOC. SEC NO. _ _ _ – _ _ – _ _ _ _
PAYROLL NUMBER: 6642 946 (HR) SAL. (CIRCLE ONE)

DATE INJURY OCCURRED: DATE REPORTED: 27 Aug 80 TIME OF INJURY: (COMPLETE)

DESCRIPTION OF INJURY: Annual Calibration Med Surv

RX:

CAUSE: 18 yrs exp.

WORK RESTRICTIONS

SUPERVISOR WHEN INJURY OCCURRED:

IF SHIFT WORKER, CIRCLE SHIFT WORKING WHEN INJURY OCCURRED: A B C D

BUILDING NUMBER, AREA, OR UNIT WHERE INJURY OCCURRED:

CIRCLE COMPLEX IN WHICH EMPLOYEE WAS WORKING WHEN INJURY OCCURRED: 1 2 3 4 5 6 7 8

IF OTHER DEPARTMENT, CIRCLE LOCATION WHERE INJURY OCCURRED: OFFICE ENGINEERING DISTRIBUTION LABORATORY MAT'LS MGMT SHIFT UTILITY MECH.

CHECK YES OR NO IN PROVIDED SPACE WHETHER OR NOT SAFETY EQUIPMENT WAS BEING USED:

	YES	NO		YES	NO	RESPIRATOR:	YES	NO
SAFETY GLASSES	☐	☐	SAFETY SHOES	☐	☐	AIR LINE	☐	☐
COVERALL GOGGLES	☐	☐	INSTEP GUARD	☐	☐	SELF-CONTAINED	☐	☐
FACE SHIELD	☐	☐				CHEMICAL CARTRIDGE	☐	☐
PVC CLOTHING	☐	☐	PLASTIC, LEATHER OR RUBBER GLOVES	☐	☐	DUST CARTRIDGE	☐	☐
COVERALLS	☐	☐	HARD HAT	☐	☐	EXPENDABLE	☐	☐
BOOTS	☐	☐	EAR PROTECTION	☐	☐	AIR CAPSULE OR SKA-PAK	☐	☐

SIGNATURE OF EMPLOYEE

ATTENDING NURSE 77 Petty

WITNESS

DISTRIBUTION OF REPORT: WHITE COPY IS FOR THE SAFETY DEPT.; YELLOW FOR DEPT. HEAD AND SHIFT SUPT
1ST AND 2ND COPIES ARE TO BE GIVEN TO THE INJURED EMPLOYEE BEFORE HE LEAVES THE MEDICAL DEPARTMENT HE WILL DELIVER THEM TO HIS SUPERVISOR WHO IS TO COMPLETE THE INJURY INVESTIGATION REPORT ON THE REVERSE

MCBEE SYSTEMS M1B019X

OPN./MAINT. COMPLEX: X 9 8 7 6 5 4 3 2 1

DEPARTMENT NUMBER: 938 | 010 | 391 | 355 | 342 | 327 | 308 | 229 | 227 | 220 | 167 | 166 | 165 | 162 | 161 | 153 | 157 | 156 | 146 | 140 | 135 | 127 | 106 | 095 | 086 | 061 | 059 | 047 | 044 | 041 | 035 | 033 | 003

MONTH: J F M A M J J A S O N D

UNSAFE ACT (USAS Z16.2 A1.8): 66 57 59 60 55 05 45 40 35 30 25 20 15 10 05

HAZARDOUS COND.: 9 8 7 6 5 4 3 2 1 0

ACCIDENT TYPE (PER USAS Z 16.2 A1.4): 10 20 30 50 60 80 100 120 130 150 181 182 183 200 300 899 999

SOURCE OF INJURY: 1 4 5 6 7 9 13 15 17 19 20 22 23 25 26 28 30 41 44 46 49 50 54 56 57 58

SEX: M F

SHIFT: A B C D

EMPLOYEE INJURY REPORT

OSHA INJURY CATEGORY: F — A LWD | B O MINOR | NAI

NATURE OF INJURY: 1 ABRASION | 2 AMPUTATION | 3 BURN (TEMP) | 4 BURN (CHEM) | 5 CONTUSION | 6 DERMATITIS | 7 DISLOCATION | 8 ELEC SHOCK | 9 FRACTURE | 10 FREEZING | 11 HEARING LOSS | 12 HEAT STROKE | 13 HERNIA | 14 LACERATION | 15 POISONING | 16 PNEUMOCONIOSIS | 17 RADIATION | 18 SCRATCHES | 19 SPRAIN | 20 MULTIPLE

PART OF BODY AFFECTED (PER USAS Z 16.2 A1.2): 120 | 130 | 140 | 150 | 200 | 311 | 313 | 315 | 320 | 330 | 340 | 410 | 420 | 430 | 440 | 450 | 511 | 513 | 515 | 520 | 530 | 540 | 700 | 850

UNION CARBIDE CORPORATION
CHEMICALS AND PLASTICS
INSTITUTE PLANT - LOCATION 512

DISABLING NO _____
OSHA NO _____

NAME: Smallridge, SW JOB CLASSIFICATION Painter

SOC. SEC NO _____ — _____ — _____

PAYROLL NUMBER: _____ HR SAL (CIRCLE ONE)

DATE INJURY OCCURRED: _____ DATE REPORTED: 27 Aug 80

TIME OF INJURY (COMPLETE): _____

DESCRIPTION OF INJURY: Removed Asbestos Med Surv.

RX:

CAUSE: 25 yrs exp.

WORK RESTRICTIONS:

SUPERVISOR WHEN INJURY OCCURRED:

IF SHIFT WORKER, CIRCLE SHIFT WORKING WHEN INJURY OCCURRED: A B C D

BUILDING NUMBER, AREA, OR UNIT WHERE INJURY OCCURRED:

CIRCLE COMPLEX IN WHICH EMPLOYEE WAS WORKING WHEN INJURY OCCURRED: 1 2 3 4 5 6 7 8

IF OTHER DEPARTMENT, CIRCLE LOCATION WHERE INJURY OCCURRED: OFFICE ENGINEERING DISTRIBUTION LABORATORY MAT'LS MGMT SHIFT UTILITY MECH.

CHECK YES OR NO IN PROVIDED SPACE WHETHER OR NOT SAFETY EQUIPMENT WAS BEING USED:

	YES	NO		YES	NO	RESPIRATOR:	YES	NO
SAFETY GLASSES	☐	☐	SAFETY SHOES	☐	☐	AIR LINE	☐	☐
COVERALL GOGGLES	☐	☐	INSTEP GUARD	☐	☐	SELF-CONTAINED	☐	☐
FACE SHIELD	☐	☐	PLASTIC, LEATHER OR			CHEMICAL CARTRIDGE	☐	☐
PVC CLOTHING	☐	☐	RUBBER GLOVES	☐	☐	DUST CARTRIDGE	☐	☐
COVERALLS	☐	☐	HARD HAT	☐	☐	EXPENDABLE	☐	☐
BOOTS	☐	☐	EAR PROTECTION	☐	☐	AIR CAPSULE OR SKA-PAK	☐	☐

SIGNATURE OF EMPLOYEE

ATTENDING NURSE: M. Pitts

WITNESS

DISTRIBUTION OF REPORT: WHITE COPY IS FOR THE SAFETY DEPT.; YELLOW FOR DEPT HEAD AND SHIFT SUPT

1ST AND 2ND COPIES ARE TO BE GIVEN TO THE INJURED EMPLOYEE BEFORE HE LEAVES THE MEDICAL DEPARTMENT. HE WILL DELIVER THEM TO HIS SUPERVISOR WHO IS TO COMPLETE THE INJURY INVESTIGATION REPORT ON THE REVERSE

MCBEE SYSTEMS M18019X

OPN./MAINT. COMPLEX: X | 9 8 7 6 5 4 3 2 1

DEPARTMENT NUMBER: 938 | 010 | 391 | 355 | 342 | 327 | 308 | 229 | 227 | 220 | 167 | 166 | 165 | 162 | 161 | 158 | 157 | 156 | 146 | 140 | 135 | 127 | 106 | 095 | 086 | 061 | 059 | 047 | 044 | 041 | 035 | 033 | 003

MONTH: D N O S A J J M A M F J

UNSAFE ACT (USAS Z16.2 A1.8): 66 75 65 60 55 50 45 40 35 30 25 20 15 10 05

HAZARDOUS COND.: 9 7 6 5 4 3 2 1 0

ACCIDENT TYPE (PER USAS Z 16.2 A1.4): 10 20 30 50 60 80 100 120 130 150 181 182 183 200 300 899 999

SOURCE OF INJURY: 25 26 28 30 41 44 46 49 50 54 56 57 58 — 1 4 5 6 7 9 13 15 17 19 20 22 23

SEX: M F

SHIFT: A B C D

UCC 017182

UCC 01783

EMPLOYEE INJURY REPORT

OSHA INJURY CATEGORY: A LWD | B O MINOR NAI.

NATURE OF INJURY: 1 ABRASION | 2 AMPUTATION | 3 BURN (TEMP) | 4 BURN (CHEM) | 5 CONTUSION | 6 DERMATITIS | 7 DISLOCATION | 8 ELEC SHOCK | 9 FRACTURE | 10 FREEZING | 11 HEARING LOSS | 12 HEAT STROKE | 13 HERNIA | 14 LACERATION | 15 POISONING | 16 PNEUMOCONIOSIS | 17 RADIATION | 18 SCRATCHES | 19 SPRAIN | 20 MULTIPLE

PART OF BODY AFFECTED (PER USAS Z 16.2 A1.2): 120 | 130 | 140 | 150 | 200 | 311 | 313 | 315 | 320 | 330 | 340 | 410 | 420 | 430 | 440 | 450 | 511 | 513 | 515 | 520 | 530 | 540 | 700 | 850

UNION CARBIDE CORPORATION
CHEMICALS AND PLASTICS
INSTITUTE PLANT - LOCATION 512

DISABLING NO. _____
OSHA NO. _____

NAME: JE Sunderland JOB CLASSIFICATION Insulator SOC. SEC NO. _____ PAYROLL NUMBER 93642-4077 (HR) SAL (CIRCLE ONE)

DATE INJURY OCCURRED: _____ DATE REPORTED: 27 Aug 80 TIME OF INJURY (COMPLETE) _____

DESCRIPTION OF INJURY: Annual Asbestos Med Exam

RX: _____

CAUSE: 21 yrs exp.

WORK RESTRICTIONS: _____

SUPERVISOR WHEN INJURY OCCURRED: _____

IF SHIFT WORKER, CIRCLE SHIFT WORKING WHEN INJURY OCCURRED: A B C D

BUILDING NUMBER, AREA, OR UNIT WHERE INJURY OCCURRED: _____

CIRCLE COMPLEX IN WHICH EMPLOYEE WAS WORKING WHEN INJURY OCCURRED: 1 2 3 4 5 6 7 8

IF OTHER DEPARTMENT, CIRCLE LOCATION WHERE INJURY OCCURRED: OFFICE ENGINEERING DISTRIBUTION LABORATORY MAT'LS MGMT SHIFT UTILITY MECH.

CHECK YES OR NO IN PROVIDED SPACE WHETHER OR NOT SAFETY EQUIPMENT WAS BEING USED:

	YES	NO		YES	NO	RESPIRATOR:	YES	NO
SAFETY GLASSES	☐	☐	SAFETY SHOES	☐	☐	AIR LINE	☐	☐
COVERALL GOGGLES	☐	☐	INSTEP GUARD	☐	☐	SELF-CONTAINED	☐	☐
FACE SHIELD	☐	☐	PLASTIC, LEATHER OR			CHEMICAL CARTRIDGE	☐	☐
PVC CLOTHING	☐	☐	RUBBER GLOVES	☐	☐	DUST CARTRIDGE	☐	☐
COVERALLS	☐	☐	HARD HAT	☐	☐	EXPENDABLE	☐	☐
BOOTS	☐	☐	EAR PROTECTION	☐	☐	AIR CAPSULE OR SKA-PAK	☐	☐

SIGNATURE OF EMPLOYEE _____ ATTENDING NURSE M Petty WITNESS _____

DISTRIBUTION OF REPORT: WHITE COPY IS FOR THE SAFETY DEPT.; YELLOW FOR DEPT. HEAD AND SHIFT SUPT

1ST AND 2ND COPIES ARE TO BE GIVEN TO THE INJURED EMPLOYEE BEFORE HE LEAVES THE MEDICAL DEPARTMENT HE WILL DELIVER THEM TO HIS SUPERVISOR WHO IS TO COMPLETE THE INJURY INVESTIGATION REPORT ON THE REVERSE

MCBEE SYSTEMS M180I9X

OPN./MAINT. COMPLEX: X | 9 8 7 6 5 4 3 2 1

DEPARTMENT NUMBER: 938 | 010 | 391 | 355 | 342 | 327 | 308 | 229 | 227 | 220 | 167 | 166 | 165 | 162 | 161 | 158 | 157 | 156 | 146 | 140 | 135 | 127 | 106 | 095 | 086 | 061 | 059 | 047 | 044 | 041 | 035 | 033 | 004 | 003

SHIFT: A B C D

SEX: M F

SOURCE OF INJURY: 1 4 5 6 7 9 13 15 17 19 20 22 23 25 26 28 30 41 44 46 49 50 54 56 57 58

ACCIDENT TYPE (PER USAS Z 16.2 A1.4): 10 20 30 50 60 80 100 120 130 150 181 182 183 200 300 899 999

MONTH: F M A M J J A S O N D

UNSAFE ACT (USAS Z16.2 A1.8): 99 75 65 60 55 50 45 40 35 30 25 20 15 10 05

HAZARDOUS COND.: 9 7 6 5 4 3 2 1 0

OSHA INJURY CATEGORY: A LWD | B O | MINOR NAI.

EMPLOYEE INJURY REPORT

NATURE OF INJURY: 1 ABRASION; 2 AMPUTATION; 3 BURN (TEMP); 4 BURN (CHEM); 5 CONTUSION; 6 DERMATITIS; 7 DISLOCATION; 8 ELEC SHOCK; 9 FRACTURE; 10 FREEZING; 11 HEARING LOSS; 12 HEAT STROKE; 13 HERNIA; 14 LACERATION; 15 POISONING; 16 PNEUMOCONIOSIS; 17 RADIATION; 18 SCRATCHES; 19 SPRAIN; 20 MULTIPLE

PART OF BODY AFFECTED (PER USAS Z 16.2 A1.2): 120 130 140 150 200 311 313 315 320 330 340 410 420 430 440 450 511 513 515 520 530 540 700 850

UNION CARBIDE CORPORATION
CHEMICALS AND PLASTICS
INSTITUTE PLANT - LOCATION 512

DISABLING NO _____
OSHA NO _____

SOC. SEC. NO _____

NAME: J.A. Williams JOB CLASSIFICATION Laborer PAYROLL NUMBER 65659 0232 (HR) SAL. (CIRCLE ONE)

DATE INJURY OCCURRED: DATE REPORTED: 27 Aug 80 TIME OF INJURY: (COMPLETE)

DESCRIPTION OF INJURY Chemical Asbestos Med Surv

RX:

CAUSE: 14 yrs exposure

WORK RESTRICTIONS

SUPERVISOR WHEN INJURY OCCURRED:

IF SHIFT WORKER, CIRCLE SHIFT WORKING WHEN INJURY OCCURRED: A B C D

BUILDING NUMBER, AREA, OR UNIT WHERE INJURY OCCURRED:

CIRCLE COMPLEX IN WHICH EMPLOYEE WAS WORKING WHEN INJURY OCCURRED: 1 2 3 4 5 6 7 8

IF OTHER DEPARTMENT, CIRCLE LOCATION WHERE INJURY OCCURRED: OFFICE ENGINEERING DISTRIBUTION LABORATORY MAT'LS MGMT SHIFT UTILITY MECH

CHECK YES OR NO IN PROVIDED SPACE WHETHER OR NOT SAFETY EQUIPMENT WAS BEING USED

	YES	NO		YES	NO	RESPIRATOR:	YES	NO
SAFETY GLASSES	☐	☐	SAFETY SHOES	☐	☐	AIR LINE	☐	☐
COVERALL GOGGLES	☐	☐	INSTEP GUARD	☐	☐	SELF-CONTAINED	☐	☐
FACE SHIELD	☐	☐	PLASTIC, LEATHER OR			CHEMICAL CARTRIDGE	☐	☐
PVC CLOTHING	☐	☐	RUBBER GLOVES	☐	☐	DUST CARTRIDGE	☐	☐
COVERALLS	☐	☐	HARD HAT	☐	☐	EXPENDABLE	☐	☐
BOOTS	☐	☐	EAR PROTECTION	☐	☐	AIR CAPSULE OR SKA-PAK	☐	☐

SIGNATURE OF EMPLOYEE

ATTENDING NURSE D J Petty

WITNESS

DISTRIBUTION OF REPORT: WHITE COPY IS FOR THE SAFETY DEPT; YELLOW FOR DEPT HEAD AND SHIFT SUPT

1ST AND 2ND COPIES ARE TO BE GIVEN TO THE INJURED EMPLOYEE BEFORE HE LEAVES THE MEDICAL DEPARTMENT HE WILL DELIVER THEM TO HIS SUPERVISOR WHO IS TO COMPLETE THE INJURY INVESTIGATION REPORT ON THE REVERSE

McGEE SYSTEMS M18019X

OPN./MAINT. COMPLEX: X 9 8 7 6 5 4 3 2 1

DEPARTMENT NUMBER: 938 010 391 355 342 327 308 229 227 220 167 166 165 162 151 158 157 156 146 140 135 127 106 095 086 061 059 047 044 041 035 033 004 003

MONTH: F M A M J J A S O N D

UNSAFE ACT (USAS Z16.2 A1.8): 66 75 65 60 55 50 45 40 35 30 25 20 15 10 05

HAZARDOUS COND.: X 9 8 7 6 5 4 3 2 1 0

UCC 017184

ACCIDENT TYPE (PER USAS Z 16.2 A1.4): 10 20 30 50 60 80 100 120 130 150 181 182 183 200 300 899 999

SOURCE OF INJURY: 1 4 5 6 7 9 13 15 17 19 20 22 23 25 26 28 30 41 44 46 49 50 54 56 57 58

SEX: M F

SHIFT: A B C D

EMPLOYEE INJURY REPORT

OSHA INJURY CATEGORY: A B LWD O MINOR NAI.

NATURE OF INJURY: 1 ABRASION, 2 AMPUTATION, 3 BURN (TEMP), 4 BURN (CHEM), 5 CONTUSION, 6 DERMATITIS, 7 DISLOCATION, 8 ELEC SHOCK, 9 FRACTURE, 10 FREEZING, 11 HEARING LOSS, 12 HEAT STROKE, 13 HERNIA, 14 LACERATION, 15 POISONING, 16 PNEUMOCONIOSIS, 17 RADIATION, 18 SCRATCHES, 19 SPRAIN, 20 MULTIPLE

PART OF BODY AFFECTED (PER USAS Z 16.2 A1.2): 120 130 140 150 200 311 313 315 320 330 340 410 420 430 440 450 511 513 515 520 530 540 700 850

UNION CARBIDE CORPORATION
CHEMICALS AND PLASTICS
INSTITUTE PLANT - LOCATION 512

DISABLING NO. ______
OSHA NO. ______

SOC SEC NO. [ ][ ][ ]-[ ][ ]-[ ][ ][ ][ ]

NAME: Witt H.E. JOB CLASSIFICATION: Insulator Shop PAYROLL NUMBER (COMPLETE): 93655 4081 HR. / SAL. (CIRCLE ONE) — HR. circled

DATE INJURY OCCURRED: DATE REPORTED: 27 Aug 80 TIME OF INJURY:

DESCRIPTION OF INJURY: Annual Aud. Med Serv

RX:

CAUSE: 19 yrs exp

WORK RESTRICTIONS:

SUPERVISOR WHEN INJURY OCCURRED:

IF SHIFT WORKER, CIRCLE SHIFT WORKING WHEN INJURY OCCURRED: A B C D

BUILDING NUMBER, AREA, OR UNIT WHERE INJURY OCCURRED:

CIRCLE COMPLEX IN WHICH EMPLOYEE WAS WORKING WHEN INJURY OCCURRED: 1 2 3 4 5 6 7 8

IF OTHER DEPARTMENT, CIRCLE LOCATION WHERE INJURY OCCURRED: OFFICE ENGINEERING DISTRIBUTION LABORATORY MAT'LS MGMT SHIFT UTILITY MECH.

CHECK YES OR NO IN PROVIDED SPACE WHETHER OR NOT SAFETY EQUIPMENT WAS BEING USED:

	YES	NO		YES	NO	RESPIRATOR.	YES	NO
SAFETY GLASSES	☐	☐	SAFETY SHOES	☐	☐	AIR LINE	☐	☐
COVERALL GOGGLES	☐	☐	INSTEP GUARD	☐	☐	SELF-CONTAINED	☐	☐
FACE SHIELD	☐	☐				CHEMICAL CARTRIDGE	☐	☐
PVC CLOTHING	☐	☐	PLASTIC, LEATHER OR RUBBER GLOVES	☐	☐	DUST CARTRIDGE	☐	☐
COVERALLS	☐	☐	HARD HAT	☐	☐	EXPENDABLE	☐	☐
BOOTS	☐	☐	EAR PROTECTION	☐	☐	AIR CAPSULE OR SKA-PAK	☐	☐

SIGNATURE OF EMPLOYEE ______ ATTENDING NURSE: M Petty WITNESS ______

DISTRIBUTION OF REPORT: WHITE COPY IS FOR THE SAFETY DEPT.; YELLOW FOR DEPT. HEAD AND SHIFT SUPT
1ST AND 2ND COPIES ARE TO BE GIVEN TO THE INJURED EMPLOYEE BEFORE HE LEAVES THE MEDICAL DEPARTMENT. HE WILL DELIVER THEM TO HIS SUPERVISOR WHO IS TO COMPLETE THE INJURY INVESTIGATION REPORT ON THE REVERSE

MCBEE SYSTEMS M18019X

OPN./MAINT. COMPLEX: 9 8 7 6 5 4 3 2 1

DEPARTMENT NUMBER: 938 010 391 355 342 327 308 229 227 220 167 166 165 162 161 158 157 156 146 140 135 127 106 095 086 061 059 047 044 041 035 033 004 003

ACCIDENT TYPE (PER USAS Z 16.2 A1.4): 10 20 30 50 60 80 100 120 130 150 181 182 183 200 300 899 999

SOURCE OF INJURY: 1 4 5 6 7 9 13 15 17 19 20 22 23 / 25 26 28 30 41 44 46 49 50 54 56 57 58

SEX: M F SHIFT: A B C D

MONTH: J F M A M J J A S O N D

UNSAFE ACT (USAS Z16.2 A1.8): 99 75 65 60 55 50 45 40 35 30 25 20 15 10 05

HAZARDOUS COND.: 0 1 2 3 4 5 6 7 9 X

EMPLOYEE INJURY REPORT

OSHA INJURY CATEGORY: F — A LWD, B LWD, O MINOR, NAI.

NATURE OF INJURY: 1 ABRASION, 2 AMPUTATION, 3 BURN (TEMP), 4 BURN (CHEM), 5 CONTUSION, 6 DERMATITIS, 7 DISLOCATION, 8 ELEC SHOCK, 9 FRACTURE, 10 FREEZING, 11 HEARING LOSS, 12 HEAT STROKE, 13 HERNIA, 14 LACERATION, 15 POISONING, 16 PNEUMOCONIOSIS, 17 RADIATION, 18 SCRATCHES, 19 SPRAIN, 20 MULTIPLE

PART OF BODY AFFECTED (PER USAS Z 16.2 A1.2): 120, 130, 140, 150, 200, 311, 313, 315, 320, 330, 340, 410, 420, 430, 440, 450, 511, 513, 515, 520, 530, 540, 700, 850

ACCIDENT TYPE (PER USAS Z 16.2 A1.4): 10, 20, 30, 50, 60, 80, 100, 120, 130, 150, 181, 182, 183, 200, 300, 899, 999

UNION CARBIDE CORPORATION
CHEMICALS AND PLASTICS
INSTITUTE PLANT - LOCATION 512

DISABLING NO. _____

OSHA NO _____

NAME: C M Wolfing Barger JOB CLASSIFICATION Painter

SOC SEC NO. _____

PAYROLL NUMBER: 93645 661 (HR) SAL. (CIRCLE ONE)

DATE INJURY OCCURRED: _____ DATE REPORTED: 27 Aug 80

TIME OF INJURY: _____ (COMPLETE)

DESCRIPTION OF INJURY: Annual Asb Med Exm

RX:

CAUSE: 28 yrs exp.

WORK RESTRICTIONS

SUPERVISOR WHEN INJURY OCCURRED:

IF SHIFT WORKER, CIRCLE SHIFT WORKING WHEN INJURY OCCURRED: A B C D

BUILDING NUMBER, AREA, OR UNIT WHERE INJURY OCCURRED:

CIRCLE COMPLEX IN WHICH EMPLOYEE WAS WORKING WHEN INJURY OCCURRED. 1 2 3 4 5 6 7 8

IF OTHER DEPARTMENT, CIRCLE LOCATION WHERE INJURY OCCURRED: OFFICE ENGINEERING DISTRIBUTION LABORATORY MAT'LS MGMT SHIFT UTILITY MECH.

CHECK YES OR NO IN PROVIDED SPACE WHETHER OR NOT SAFETY EQUIPMENT WAS BEING USED.

	YES	NO		YES	NO	RESPIRATOR.	YES	NO
SAFETY GLASSES	☐	☐	SAFETY SHOES	☐	☐	AIR LINE	☐	☐
COVERALL GOGGLES	☐	☐	INSTEP GUARD	☐	☐	SELF-CONTAINED	☐	☐
FACE SHIELD	☐	☐	PLASTIC, LEATHER OR			CHEMICAL CARTRIDGE	☐	☐
PVC CLOTHING	☐	☐	RUBBER GLOVES	☐	☐	DUST CARTRIDGE	☐	☐
COVERALLS	☐	☐	HARD HAT	☐	☐	EXPENDABLE	☐	☐
BOOTS	☐	☐	EAR PROTECTION	☐	☐	AIR CAPSULE OR SKA-PAK	☐	☐

SIGNATURE OF EMPLOYEE

ATTENDING NURSE M. Petty

WITNESS

DISTRIBUTION OF REPORT: WHITE COPY IS FOR THE SAFETY DEPT., YELLOW FOR DEPT. HEAD AND SHIFT SUPT

1ST AND 2ND COPIES ARE TO BE GIVEN TO THE INJURED EMPLOYEE BEFORE HE LEAVES THE MEDICAL DEPARTMENT. HE WILL DELIVER THEM TO HIS SUPERVISOR WHO IS TO COMPLETE THE INJURY INVESTIGATION REPORT ON THE REVERSE

MCBEE SYSTEMS M180193X

UCC 017186

MONTH: J F M A M J J A S O N D

UNSAFE ACT (USAS Z16.2 A1.8): 05 10 15 20 25 30 35 40 45 50 55 60 65 75 85

HAZARDOUS COND.: 0 1 2 3 4 5 6 7 8 9

SOURCE OF INJURY: 1 4 5 6 7 9 13 15 17 19 20 22 23 25 26 28 30 41 44 46 49 50 54 56 57 58

SEX: M F

SHIFT: A B C D

OPN./MAINT. COMPLEX: X — 9 8 7 6 5 4 3 2 1

DEPARTMENT NUMBER: 938 010 391 355 342 327 308 223 227 220 167 166 165 162 161 158 157 156 146 140 135 127 106 095 086 061 059 047 044 041 035 033 004 003

EMPLOYEE INJURY REPORT

OSHA INJURY CATEGORY: A LWD | B | O MINOR | NAI.

NATURE OF INJURY: 1 ABRASION | 2 AMPUTATION | 3 BURN (TEMP) | 4 BURN (CHEM) | 5 CONTUSION | 6 DERMATITIS | 7 DISLOCATION | 8 ELEC SHOCK | 9 FRACTURE | 10 FREEZING | 11 HEARING LOSS | 12 HEAT STROKE | 13 HERNIA | 14 LACERATION | 15 POISONING | 16 PNEUMOCONIOSIS | 17 RADIATION | 18 SCRATCHES | 19 SPRAIN | 20 MULTIPLE

PART OF BODY AFFECTED (PER USAS Z 16.2 A1.2): 120 | 130 | 140 | 150 | 200 | 311 | 313 | 315 | 320 | 330 | 340 | 410 | 420 | 430 | 440 | 450 | 511 | 513 | 515 | 520

ACCIDENT TYPE (PER USAS Z 16.2 A1.4): 530 | 540 | 700 | 850 | 10 | 20 | 30 | 50 | 60 | 80 | 100 | 120 | 130 | 150 | 181 | 182 | 183 | 200 | 300 | 899 | 999

UNION CARBIDE CORPORATION
CHEMICALS AND PLASTICS
INSTITUTE PLANT - LOCATION 512

DISABLING NO. _____

OSHA NO. _____

NAME: Campbell C.K. JOB CLASSIFICATION: Supervisor

SOC SEC NO. ___ — ___ — ____

PAYROLL NUMBER: 46985468 HR. SAL. (CIRCLE ONE)

TIME OF INJURY (COMPLETE)

DATE INJURY OCCURRED: DATE REPORTED: 27 Aug 80

DESCRIPTION OF INJURY: Annual Asbestos Med. Surv.

RX:

CAUSE: 15 yrs exp

WORK RESTRICTIONS

SUPERVISOR WHEN INJURY OCCURRED:

IF SHIFT WORKER, CIRCLE SHIFT WORKING WHEN INJURY OCCURRED: A B C D

BUILDING NUMBER, AREA, OR UNIT WHERE INJURY OCCURRED:

CIRCLE COMPLEX IN WHICH EMPLOYEE WAS WORKING WHEN INJURY OCCURRED: 1 2 3 4 5 6 7 8

IF OTHER DEPARTMENT, CIRCLE LOCATION WHERE INJURY OCCURRED: OFFICE ENGINEERING DISTRIBUTION LABORATORY MAT'LS MGMT SHIFT UTILITY MECH.

CHECK YES OR NO IN PROVIDED SPACE WHETHER OR NOT SAFETY EQUIPMENT WAS BEING USED:

	YES	NO		YES	NO	RESPIRATOR:	YES	NO
SAFETY GLASSES	☐	☐	SAFETY SHOES	☐	☐	AIR LINE	☐	☐
COVERALL GOGGLES	☐	☐	INSTEP GUARD	☐	☐	SELF-CONTAINED	☐	☐
FACE SHIELD	☐	☐	PLASTIC, LEATHER OR RUBBER GLOVES	☐	☐	CHEMICAL CARTRIDGE	☐	☐
PVC CLOTHING	☐	☐	HARD HAT	☐	☐	DUST CARTRIDGE	☐	☐
COVERALLS	☐	☐	EAR PROTECTION	☐	☐	EXPENDABLE	☐	☐
BOOTS	☐	☐				AIR CAPSULE OR SKA-PAK	☐	☐

SIGNATURE OF EMPLOYEE

ATTENDING NURSE: M Patty

WITNESS

DISTRIBUTION OF REPORT: WHITE COPY IS FOR THE SAFETY DEPT.; YELLOW FOR DEPT. HEAD AND SHIFT SUPT.

1ST AND 2ND COPIES ARE TO BE GIVEN TO THE INJURED EMPLOYEE BEFORE HE LEAVES THE MEDICAL DEPARTMENT HE WILL DELIVER THEM TO HIS SUPERVISOR WHO IS TO COMPLETE THE INJURY INVESTIGATION REPORT ON THE REVERSE

McBEE SYSTEMS M18019X

OPN./MAINT. COMPLEX: X | 9 | 8 | 7 | 6 | 5 | 4 | 3 | 2 | 1

DEPARTMENT NUMBER: 938 | 010 | 391 | 355 | 342 | 327 | 308 | 229 | 227 | 220 | 167 | 166 | 165 | 162 | 161 | 158 | 157 | 156 | 146 | 140 | 135 | 127 | 106 | 095 | 086 | 061 | 059 | 047 | 044 | 041 | 035 | 033 | 004 | 003

SOURCE OF INJURY: 1 4 5 6 7 9 13 15 17 19 20 22 23 | 25 26 28 30 41 44 46 49 50 54 56 57 58

SEX: M F

SHIFT: A B C D

MONTH: F M A M J J A S O N D

UNSAFE ACT (USAS Z16.2 A1.8): 66 75 65 60 55 50 45 40 35 30 25 20 15 10 05

HAZARDOUS COND.: 9 7 6 5 4 3 2 1 0

UCC 01787

EMPLOYEE INJURY REPORT

OSHA INJURY CATEGORY: A LWD | B O | MINOR NAI.

NATURE OF INJURY: 1 ABRASION; 2 AMPUTATION; 3 BURN (TEMP); 4 BURN (CHEM); 5 CONTUSION; 6 DERMATITIS; 7 DISLOCATION; 8 ELEC SHOCK; 9 FRACTURE; 10 FREEZING; 11 HEARING LOSS; 12 HEAT STROKE; 13 HERNIA; 14 LACERATION; 15 POISONING; 16 PNEUMOCONIOSIS; 17 RADIATION; 18 SCRATCHES; 19 SPRAIN; 20 MULTIPLE

PART OF BODY AFFECTED (PER USAS Z 16.2 A1.2): 120; 130; 140; 150; 200; 311; 313; 315; 320; 330; 340; 410; 420; 430; 440; 450; 511; 513; 515; 520; 530; 540; 700; 850

UNION CARBIDE CORPORATION
CHEMICALS AND PLASTICS
INSTITUTE PLANT - LOCATION 512

DISABLING NO _____

OSHA NO _____

NAME: D L Johnson JOB CLASSIFICATION Supervisor SOC. SEC. NO _____ PAYROLL NUMBER 469-91445 HR. SAL (CIRCLE ONE)

DATE INJURY OCCURRED: _____ DATE REPORTED: 27 Aug 80 TIME OF INJURY: _____ (COMPLETE)

DESCRIPTION OF INJURY: Cornea Abr Med Sent

RX:

CAUSE: Flying object

WORK RESTRICTIONS

SUPERVISOR WHEN INJURY OCCURRED:

IF SHIFT WORKER, CIRCLE SHIFT WORKING WHEN INJURY OCCURRED: A B C D

BUILDING NUMBER, AREA, OR UNIT WHERE INJURY OCCURRED:

CIRCLE COMPLEX IN WHICH EMPLOYEE WAS WORKING WHEN INJURY OCCURRED: 1 2 3 4 5 6 7 8

IF OTHER DEPARTMENT, CIRCLE LOCATION WHERE INJURY OCCURRED: OFFICE ENGINEERING DISTRIBUTION LABORATORY MAT'LS MGMT SHIFT UTILITY MECH.

CHECK YES OR NO IN PROVIDED SPACE WHETHER OR NOT SAFETY EQUIPMENT WAS BEING USED:

	YES	NO		YES	NO	RESPIRATOR:	YES	NO
SAFETY GLASSES	☐	☐	SAFETY SHOES	☐	☐	AIR LINE	☐	☐
COVERALL GOGGLES	☐	☐	INSTEP GUARD	☐	☐	SELF-CONTAINED	☐	☐
FACE SHIELD	☐	☐				CHEMICAL CARTRIDGE	☐	☐
PVC CLOTHING	☐	☐	PLASTIC, LEATHER OR RUBBER GLOVES	☐	☐	DUST CARTRIDGE	☐	☐
COVERALLS	☐	☐	HARD HAT	☐	☐	EXPENDABLE	☐	☐
BOOTS	☐	☐	EAR PROTECTION	☐	☐	AIR CAPSULE OR SKA-PAK	☐	☐

SIGNATURE OF EMPLOYEE

ATTENDING NURSE D Pitts

WITNESS

DISTRIBUTION OF REPORT: WHITE COPY IS FOR THE SAFETY DEPT.; YELLOW FOR DEPT. HEAD AND SHIFT SUPT

1ST AND 2ND COPIES ARE TO BE GIVEN TO THE INJURED EMPLOYEE BEFORE HE LEAVES THE MEDICAL DEPARTMENT HE WILL DELIVER THEM TO HIS SUPERVISOR WHO IS TO COMPLETE THE INJURY INVESTIGATION REPORT ON THE REVERSE

McGEE SYSTEMS M18019X

OPN./MAINT. COMPLEX: X 9 8 7 6 5 4 3 2 1

DEPARTMENT NUMBER: 938; 010; 391; 355; 342; 327; 308; 229; 227; 220; 167; 166; 165; 162; 161; 158; 157; 156; 146; 140; 135; 127; 105; 095; 086; 061; 059; 047; 044; 041; 035; 033; 004; 003

MONTH: J F M A M J J A S O N D

UNSAFE ACT (USAS Z16.2 A1.8): 05 10 15 20 25 30 35 40 45 50 55 60 65 75 66

HAZARDOUS COND.: 0 1 2 3 4 5 6 7 8 9

ACCIDENT TYPE (PER USAS Z 16.2 A1.4): 10; 20; 30; 50; 60; 80; 100; 120; 130; 150; 181; 182; 183; 200; 300; 899; 999

SOURCE OF INJURY: 1 4 5 6 7 9 13 15 17 19 20 22 23 25 26 28 30 41 44 46 49 50 54 56 57 58

SEX: M F

SHIFT: A B C D

UCC 017188

UCC 017189

OSHA INJURY CATEGORY: A LWD | B O | MINOR NAI.

EMPLOYEE INJURY REPORT

NATURE OF INJURY: 1 ABRASION; 2 AMPUTATION; 3 BURN (TEMP); 4 BURN (CHEM); 5 CONTUSION; 6 DERMATITIS; 7 DISLOCATION; 8 ELEC SHOCK; 9 FRACTURE; 10 FREEZING; 11 HEARING LOSS; 12 HEAT STROKE; 13 HERNIA; 14 LACERATION; 15 POISONING; 16 PNEUMOCONIOSIS; 17 RADIATION; 18 SCRATCHES; 19 SPRAIN; 20 MULTIPLE

PART OF BODY AFFECTED (PER USAS Z 16.2 A1.2): 120 130 140 150 200 311 313 315 320 330 340 410 420 430 440 450 511 513 515 520 530 540 700 850

UNION CARBIDE CORPORATION
CHEMICALS AND PLASTICS
INSTITUTE PLANT - LOCATION 512

DISABLING NO _____
OSHA NO _____

ACCIDENT TYPE (PER USAS Z 16.2 A1.4): 10 20 30 50 60 80 100 120 130 150 181 182 183 200 300 899 999

NAME: L.H. Wodson JOB CLASSIFICATION: Supervisor SOC. SEC NO. _____ PAYROLL NUMBER: 469 33185 HR. SAL. (CIRCLE ONE)

DATE INJURY OCCURRED: _____ DATE REPORTED: 27 Aug 80 TIME OF INJURY: _____ (COMPLETE)

DESCRIPTION OF INJURY: Cumulative Sob. Med Surd

RX:

CAUSE: 32 yrs exp

WORK RESTRICTIONS:

SUPERVISOR WHEN INJURY OCCURRED: _____

IF SHIFT WORKER, CIRCLE SHIFT WORKING WHEN INJURY OCCURRED: A B C D

BUILDING NUMBER, AREA, OR UNIT WHERE INJURY OCCURRED: _____

CIRCLE COMPLEX IN WHICH EMPLOYEE WAS WORKING WHEN INJURY OCCURRED: 1 2 3 4 5 6 7 8

IF OTHER DEPARTMENT, CIRCLE LOCATION WHERE INJURY OCCURRED: OFFICE ENGINEERING DISTRIBUTION LABORATORY MAT'LS MGMT SHIFT UTILITY MECH.

CHECK YES OR NO IN PROVIDED SPACE WHETHER OR NOT SAFETY EQUIPMENT WAS BEING USED:

	YES	NO		YES	NO	RESPIRATOR	YES	NO
SAFETY GLASSES	☐	☐	SAFETY SHOES	☐	☐	AIR LINE	☐	☐
COVERALL GOGGLES	☐	☐	INSTEP GUARD	☐	☐	SELF-CONTAINED	☐	☐
FACE SHIELD	☐	☐	PLASTIC, LEATHER OR RUBBER GLOVES	☐	☐	CHEMICAL CARTRIDGE	☐	☐
PVC CLOTHING	☐	☐	HARD HAT	☐	☐	DUST CARTRIDGE	☐	☐
COVERALLS	☐	☐	EAR PROTECTION	☐	☐	EXPENDABLE	☐	☐
BOOTS	☐	☐				AIR CAPSULE OR SKA-PAK	☐	☐

SIGNATURE OF EMPLOYEE _____ ATTENDING NURSE M Pettey WITNESS _____

DISTRIBUTION OF REPORT: WHITE COPY IS FOR THE SAFETY DEPT. YELLOW FOR DEPT HEAD AND SHIFT SUPT

1ST AND 2ND COPIES ARE TO BE GIVEN TO THE INJURED EMPLOYEE BEFORE HE LEAVES THE MEDICAL DEPARTMENT HE WILL DELIVER THEM TO HIS SUPERVISOR WHO IS TO COMPLETE THE INJURY INVESTIGATION REPORT ON THE REVERSE

McGEE SYSTEMS M18019X

OPN./MAINT. COMPLEX: X 9 8 7 6 5 4 3 2 1

DEPARTMENT NUMBER: 938 010 391 355 342 327 308 229 227 220 167 166 165 162 161 158 157 156 146 140 135 127 106 095 086 061 059 047 044 041 035 033 004 003

SOURCE OF INJURY: 1 4 5 6 7 9 13 15 17 19 20 22 23 25 26 28 30 41 44 46 49 50 54 56 57 58

SEX: M F

SHIFT: A B C D

MONTH: F M A M J J A S O N D

UNSAFE ACT (USAS Z16.2 A1.8): 88 87 86 85 84 83 82 81 80 79 78 77 76 75 74 73 72 71 70 69 68 67 66 65 64 63 62 61 60 59 58 57 56 55 54 53 52 51 50

HAZARDOUS COND.: 9 8 7 6 5 4 3 2 1 0

EMPLOYEE INJURY REPORT

OSHA INJURY CATEGORY: A B LWD O MINOR NAI.

NATURE OF INJURY: 1 ABRASION | 2 AMPUTATION | 3 BURN (TEMP) | 4 BURN (CHEM) | 5 CONTUSION | 6 DERMATITIS | 7 DISLOCATION | 8 ELEC SHOCK | 9 FRACTURE | 10 FREEZING | 11 HEARING LOSS | 12 HEAT STROKE | 13 HERNIA | 14 LACERATION | 15 POISONING | 16 PNEUMOCONIOSIS | 17 RADIATION | 18 SCRATCHES | 19 SPRAIN | 20 MULTIPLE

PART OF BODY AFFECTED (PER USAS Z 16.2 A1.2): 120 130 140 150 200 311 313 315 320 330 340 410 420 430 440 450 511 513 515 520 530 540 700 850

ACCIDENT TYPE (PER USAS Z 16.2 A1.4): 10 20 30 50 60 80 100 120 130 150 181 182 183 200 300 899 999

UNION CARBIDE CORPORATION
CHEMICALS AND PLASTICS
INSTITUTE PLANT - LOCATION 512

DISABLING NO ______
OSHA NO ______

SOC. SEC. NO. ___-__-____

NAME: Young PW JOB CLASSIFICATION Supervisor

PAYROLL NUMBER 469-85469 (COMPLETE) HR. SAL. (CIRCLE ONE)

DATE INJURY OCCURRED: DATE REPORTED: 27 Aug 80 TIME OF INJURY:

DESCRIPTION OF INJURY: Annual Adv Med Serv

RX:

CAUSE: 36 yrs exp

WORK RESTRICTIONS

SUPERVISOR WHEN INJURY OCCURRED:

IF SHIFT WORKER, CIRCLE SHIFT WORKING WHEN INJURY OCCURRED: A B C D

BUILDING NUMBER, AREA, OR UNIT WHERE INJURY OCCURRED:

CIRCLE COMPLEX IN WHICH EMPLOYEE WAS WORKING WHEN INJURY OCCURRED. 1 2 3 4 5 6 7 8

IF OTHER DEPARTMENT, CIRCLE LOCATION WHERE INJURY OCCURRED: OFFICE ENGINEERING DISTRIBUTION LABORATORY MAT'LS MGMT SHIFT UTILITY MECH.

CHECK YES OR NO IN PROVIDED SPACE WHETHER OR NOT SAFETY EQUIPMENT WAS BEING USED:

	YES	NO		YES	NO	RESPIRATOR:	YES	NO
SAFETY GLASSES	☐	☐	SAFETY SHOES	☐	☐	AIR LINE	☐	☐
COVERALL GOGGLES	☐	☐	INSTEP GUARD	☐	☐	SELF-CONTAINED	☐	☐
FACE SHIELD	☐	☐				CHEMICAL CARTRIDGE	☐	☐
PVC CLOTHING	☐	☐	PLASTIC, LEATHER OR RUBBER GLOVES	☐	☐	DUST CARTRIDGE	☐	☐
COVERALLS	☐	☐	HARD HAT	☐	☐	EXPENDABLE	☐	☐
BOOTS	☐	☐	EAR PROTECTION	☐	☐	AIR CAPSULE OR SKA-PAK	☐	☐

SIGNATURE OF EMPLOYEE ______ ATTENDING NURSE B. Pott WITNESS ______

DISTRIBUTION OF REPORT: WHITE COPY IS FOR THE SAFETY DEPT.; YELLOW FOR DEPT. HEAD AND SHIFT SUPT
1ST AND 2ND COPIES ARE TO BE GIVEN TO THE INJURED EMPLOYEE BEFORE HE LEAVES THE MEDICAL DEPARTMENT HE WILL DELIVER THEM TO HIS SUPERVISOR WHO IS TO COMPLETE THE INJURY INVESTIGATION REPORT ON THE REVERSE.

MCBEE SYSTEMS M18019X

OPN./MAINT. COMPLEX: 9 8 7 6 5 4 3 2 1

DEPARTMENT NUMBER: 938 010 391 355 342 327 308 229 227 220 167 166 165 162 161 158 157 156 146 140 135 127 106 095 086 061 059 047 044 041 035 033 004 003

SOURCE OF INJURY: 1 4 5 6 7 9 13 15 17 19 20 22 23 25 26 28 30 41 44 46 49 50 54 56 57 58

SEX: M F

SHIFT: A B C D

MONTH: J F M A M J J A S O N D

UNSAFE ACT (USAS Z16.2 A1.8): 05 10 15 20 25 30 35 40 45 50 55 60 65 75 99

HAZARDOUS COND.: X 0 1 2 3 4 5 6 7 8 9

UCC 017190

UCC 011791

OSHA INJURY CATEGORY: A LWD | B MINOR | O NAI.

EMPLOYEE ~~INJURY~~ REPORT

NATURE OF INJURY: Illness

1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20
ABRASION	AMPUTATION	BURN (TEMP)	BURN (CHEM)	CONTUSION	DERMATITIS	DISLOCATION	ELEC SHOCK	FRACTURE	FREEZING	HEARING LOSS	HEAT STROKE	HERNIA	LACERATION	POISONING	PNEUMOCONIOSIS	RADIATION	SCRATCHES	SPRAIN	MULTIPLE

120	130	140	150	200	311	313	315	320	330	340	410	420	430	440	450	511	513	515	520

PART OF BODY AFFECTED (PER USAS Z 16.2 A1.2)

UNION CARBIDE CORPORATION
CHEMICALS AND PLASTICS
INSTITUTE PLANT - LOCATION 512

DISABLING NO _____

OSHA NO _____

NAME: Clark, W. M. JOB CLASSIFICATION Rigger SOC. SEC NO. ___-__-____

PAYROLL NUMBER: 25135126 (HR) SAL. (CIRCLE ONE)

DATE INJURY OCCURRED: DATE REPORTED: 12-Dec 80 TIME OF INJURY. (COMPLETE)

DESCRIPTION OF INJURY: Asbestosis

RX:

CAUSE: - Asbestosis - 50 yr history - working with asbestos

WORK RESTRICTIONS

SUPERVISOR WHEN INJURY OCCURRED:

IF SHIFT WORKER, CIRCLE SHIFT WORKING WHEN INJURY OCCURRED: A B C D

BUILDING NUMBER, AREA, OR UNIT WHERE INJURY OCCURRED:

CIRCLE COMPLEX IN WHICH EMPLOYEE WAS WORKING WHEN INJURY OCCURRED: 1 2 3 4 5 6 7 8

IF OTHER DEPARTMENT, CIRCLE LOCATION WHERE INJURY OCCURRED: OFFICE ENGINEERING DISTRIBUTION LABORATORY MAT'LS MGMT SHIFT UTILITY MECH.

CHECK YES OR NO IN PROVIDED SPACE WHETHER OR NOT SAFETY EQUIPMENT WAS BEING USED:

	YES	NO		YES	NO	RESPIRATOR:	YES	NO
SAFETY GLASSES	☐	☐	SAFETY SHOES	☐	☐	AIR LINE	☐	☐
COVERALL GOGGLES	☐	☐	INSTEP GUARD	☐	☐	SELF-CONTAINED	☐	☐
FACE SHIELD	☐	☐				CHEMICAL CARTRIDGE	☐	☐
PVC CLOTHING	☐	☐	PLASTIC, LEATHER OR RUBBER GLOVES	☐	☐	DUST. CARTRIDGE	☐	☐
COVERALLS	☐	☐	HARD HAT	☐	☐	EXPENDABLE	☐	☐
BOOTS	☐	☐	EAR PROTECTION	☐	☐	AIR CAPSULE OR SKA-PAK	☐	☐

SIGNATURE OF EMPLOYEE

ATTENDING NURSE

WITNESS

DISTRIBUTION OF REPORT: WHITE COPY IS FOR THE SAFETY DEPT.; YELLOW FOR DEPT. HEAD AND SHIFT SUPT.

1ST AND 2ND COPIES ARE TO BE GIVEN TO THE INJURED EMPLOYEE BEFORE HE LEAVES THE MEDICAL DEPARTMENT HE WILL DELIVER THEM TO HIS SUPERVISOR WHO IS TO COMPLETE THE INJURY INVESTIGATION REPORT ON THE REVERSE.

McGEE SYSTEMS M180192

OPN./MAINT. COMPLEX: X 9 8 7 6 5 4 3 2 1

DEPARTMENT NUMBER: 938 010 391 355 342 327 308 229 227 220 167 166 165 162 161 158 157 156 146 140 135 127 106 095 086 061 059 047 044 041 035 033 004 003

ACCIDENT TYPE (PER USAS Z 16.2 A1.4): 520 540 700 850 10 20 30 50 60 80 100 120 130 150 181 182 183 200 300 899 999

SOURCE OF INJURY: 1 4 5 6 7 9 13 15 17 19 20 22 23 25 26 28 30 41 44 46 49 50 54 56 57 58

SEX: M F

SHIFT: A B C D

UNSAFE ACT (USAS Z16.2 A1.8): 66 75 65 60 55 50 45 40 35 30 25 20 15 10 05 00

HAZARDOUS COND.: 9 8 7 6 5 4 3 2 1 0

MONTH: F J A M J J A S O N D

OSHA INJURY CATEGORY: F | B LWD | O | MINOR | NAI

EMPLOYEE INJURY/ILLNESS REPORT

NATURE OF INJURY OR ILLNESS: 1 ABRASION | 2 AMPUTATION | 3 BURN (TEMP) | 4 BURN (CHEM) | 5 CONTUSION | 6 DERMATITIS | 7 DISLOCATION | 8 ELEC. SHOCK | 9 FRACTURE | 10 FREEZING | 11 HEARING LOSS | 12 HEAT STROKE | 13 HERNIA | 14 LACERATION | 15 POISONING | 16 PNEUMOCONIOSIS | 17 RADIATION | 18 SCRATCHES | 19 SPRAIN | 20 MULTIPLE

PART OF BODY AFFECTED (PER USAS Z 16.2 A1.2): 120 | 130 | 140 | 150 | 200 | 311 | 313 | 315 | 320 | 330 | 340 | 410 | 420 | 430 | 440 | 450 | 511 | 513 | 515 | 520 | 530 | 540 | 700 | 850

UNION CARBIDE CORPORATION
AGRICULTURAL PRODUCTS CO.
INSTITUTE PLANT - LOCATION 512

DISABLING NO. _____
OSHA NO. _____

NAME: Worden, L L JOB CLASSIFICATION Sheet Metal SOC. SEC. NO. [ ] – [ ] – [ ]

PAYROLL NUMBER: 43652-46 (HR.) SAL. (CIRCLE ONE)

DATE INJURY OCCURRED: DATE REPORTED: 7 Mar 86 TIME OF INJURY: (COMPLETE)

DESCRIPTION OF INJURY: Asbestos related - Pleural Thickening

RX:

CAUSE: (SD) 1962 - Insulator 4 yrs - Operations Mgr.
Laborer - 2 - Metal Fab Shop 18 yrs

WORK RESTRICTIONS

SUPERVISOR WHEN INJURY OCCURRED:

IF SHIFT WORKER, CIRCLE SHIFT WORKING WHEN INJURY OCCURRED: A B C D

BUILDING NUMBER, AREA, OR UNIT WHERE INJURY OCCURRED:

CIRCLE COMPLEX IN WHICH EMPLOYEE WAS WORKING WHEN INJURY OCCURRED: 1 2 3 4 5 6 7 8

IF OTHER THAN OPERATIONS OR MAINTENANCE, CIRCLE LOCATION WHERE INJURY OCCURRED: OFFICE ENGINEERING DISTRIBUTION LABORATORY MAT'LS MGMT SHIFT UTILITY MECH.

CHECK YES OR NO IN PROVIDED SPACE WHETHER OR NOT SAFETY EQUIPMENT WAS BEING USED:

	YES	NO		YES	NO
SAFETY GLASSES	☐	☐	SAFETY SHOES	☐	☐
COVERALL GOGGLES	☐	☐	INSTEP GUARD	☐	☐
FACE SHIELD	☐	☐	PLASTIC, LEATHER OR RUBBER GLOVES	☐	☐
PVC CLOTHING	☐	☐	HARD HAT	☐	☐
COVERALLS	☐	☐	HEARING PROTECTION	☐	☐
BOOTS	☐	☐			

RESPIRATOR:

	YES	NO
AIR LINE	☐	☐
SELF-CONTAINED	☐	☐
CHEMICAL CARTRIDGE	☐	☐
DUST CARTRIDGE	☐	☐
DISPOSABLE	☐	☐
AIR CAPSULE OR SKA-PAK	☐	☐

Larry L Worden
SIGNATURE OF EMPLOYEE

B. Chambliss R.N.
ATTENDING NURSE

WITNESS

DISTRIBUTION OF REPORT: WHITE COPY IS FOR THE SAFETY DEPT.; YELLOW FOR DEPT. HEAD AND SHIFT SUPT.
1ST AND 2ND COPIES ARE TO BE GIVEN TO THE INJURED EMPLOYEE BEFORE HE LEAVES THE MEDICAL DEPARTMENT. HE WILL DELIVER THEM TO HIS SUPERVISOR WHO IS TO COMPLETE THE INJURY INVESTIGATION REPORT ON THE REVERSE

OPN./MAINT. COMPLEX: X | 9 8 7 6 5 4 3 2 1

DEPARTMENT NUMBER: 938 | 391 | 370 | 355 | 342 | 327 | 308 | 229 | 227 | 220 | 165 | 162 | 161 | 158 | 157 | 156 | 146 | 140 | 135 | 127 | 106 | 095 | 086 | 061 | 059 | 047 | 044 | 041 | 035 | 007 | 004

MONTH: J F M A M J J A S O N D

UNSAFE ACT (USAS Z16.2 A1.8): 66 | 75 | 65 | 60 | 55 | 50 | 45 | 40 | 35 | 30 | 25 | 20 | 15 | 10 | 05

HAZARDOUS COND.: 9 | 8 | 7 | 6 | 5 | 4 | 3 | 2 | 1 | 0

UCC 011792

ACCIDENT TYPE (PER USAS Z 16.2 A1.4): 10 | 20 | 30 | 50 | 60 | 80 | 100 | 120 | 130 | 150 | 181 | 182 | 183 | 200 | 300 | 899 | 999

SOURCE OF INJURY: 1 | 4 | 5 | 6 | 7 | 9 | 13 | 15 | 17 | 19 | 20 | 22 | 23 | 25 | 26 | 28 | 30 | 41 | 44 | 46 | 49 | 50 | 54 | 56 | 57 | 58

SEX: M F

SHIFT: A B C D