

Department of Labor and Industries  
 PO Box 44291  
 Olympia WA 98504-4291



# EMPLOYMENT HISTORY HEARING LOSS

Claim Number

Name

Start date of first employment

Please list any BREAK or INTERRUPTION in your work history. We must account for all months since your FIRST START DATE

From (Month/Year)	To (Month/Year)	Reason for work interruption

## Employment History

**BEGIN WITH YOUR CURRENT JOB AND LIST ALL PRIOR EMPLOYERS. INCLUDE MILITARY SERVICE.**

Please start with your most RECENT job and work BACKWARDS. Specify month and year for employment date

Employer's Business Name	From (Month/Year)	To (Month/Year)
Employer's Address	City	State ZIP + 4
Job Title	Employer's Phone No.	Indicate time exposed to noise in <u>hours per week</u>

Describe job duties, type of machinery, tools, material, equipment used, and percentage of time at duties:

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Were you exposed to loud noise on this job? If yes, please describe the noise source:

Yes  No

Would you describe the noise as continuous?  Yes  No  Or intermittent?  Yes  No

How many hours a day were you exposed to this job noise? \_\_\_\_\_ hours

What kind of ear protection did you use?  None  ear muffs  plastic ear plugs  foam ear plugs

Other – please specify

Did you have an audiogram while employed by this employer?  Yes  No

Date(s) of audiogram(s)

I certify that the information is true and correct to the best of my knowledge.

Date

Signature