**Medical History and Examination for Coal Mine Workers' Pneumoconiosis**

Reset Print

**U.S. Department of Labor**
**Office of Workers' Compensation Programs**
**Division of Coal Mine Workers' Compensation**

**Note: This report is authorized by law (30 USC 901 et. seq.) and required to receive a benefit. The results of this examination will aid in determining the miner's eligibility for black lung benefits. The method of collecting information complies with the Freedom of Information Act, the Privacy Act of 1974, and OMB Cir. No. 108.**

OMB No.:1240-0023
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## A. Patient Information (Please type or neatly print all responses.)

**1. Name and Address**

**2. DOL's Case ID Number**

**3. Telephone Number**

**4. Date of Exam**

**5. Date of Birth**

**6. Personal Physician (name, address, phone number)**

Phone:

**7. Examining Physician (name, address, phone number)**

Phone:

## B. Employment History (Please type or neatly print all responses.)

☐ "Employment History," Form CM-911a or equivalent (dated _____) is attached. Please review the form and, with the miner's help, **complete block 1.a, below describing his / her most recent coal mine job of at least one year's duration. Also complete block 1.d. (personal protective equipment).** Then, move on to "C. Patient History."

☐ CM-911a is not attached – complete both sections 1. and 2. below.

**1. Coal Mine Employment – CME. List most recent employers first. In line (a.) describe the last job of at least one year's duration and specify the exertional level of the job. (Include in all lines any coal mine construction or transportation work, or work in a mine preparation facility.**

| Name of Company | Job Title and Description of Job's Physical Requirements | From (mm/yyyy) | To (mm/yyyy) |
|---|---|---|---|
| a. Last CME held at least one year: | Title:<br>Description of physical requirements:<br>Level of exertion: ◯ Light ◯ Moderate ◯ Heavy ◯ Very heavy | | |
| b. Other CME: | | | |

c. Additional number of years in CME not described above: _____ years

d. Did the miner regularly use personal protective equipment? ◯ Yes ◯ No

If yes, what type of personal protective equipment did the miner use? _____

**2. Other Employment – Not CME.** (If the employment exposed the claimant to an occupational toxic inhalant hazard, describe the inhalant under "Job Title and Description.")

| Name of Company | Job Title and Description | From (mm/yyyy) | To (mm/yyyy) |
|---|---|---|---|
| | | | |
| | | | |

## C. Patient History (Family – Medical – Social) (Please type or neatly print all responses.)

**1. Family History.**
**Have the patient's parents, children, or other "blood" relatives ever had any of the following? (Check all that apply):**

| | High Blood Pressure | Heart Disease | TB | Asthma | Allergies | Emphysema | Stroke | Diabetes |
|---|---|---|---|---|---|---|---|---|
| Mother | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Father | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Siblings | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |
| Children | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ | ☐ |

**2. Individual Health/Medical History**

a. Does the patient have a history of :

| Yes | No | When Manifested (mm/yy) | Yes | No | When Manifested (mm/yy) |
|---|---|---|---|---|---|
| ☐ | ☐ | Frequent Colds | ☐ | ☐ | Arthritis |
| ☐ | ☐ | Pneumonia | ☐ | ☐ | Heart Disease/Problems |
| ☐ | ☐ | Pleurisy | ☐ | ☐ | Allergies |
| ☐ | ☐ | Attacks of wheezing | ☐ | ☐ | Cancer (of _____ ) |
| ☐ | ☐ | Tuberculosis | ☐ | ☐ | Diabetes Mellitus |
| ☐ | ☐ | Chronic Bronchitis | ☐ | ☐ | High Blood Pressure |
| ☐ | ☐ | Bronchial Asthma | ☐ | ☐ | Connective Tissue Disease |
| ☐ | ☐ | Histoplasmosis | ☐ | ☐ | Other |
| ☐ | ☐ | Emphysema | ☐ | ☐ | Other |
| ☐ | ☐ | Stroke | ☐ | ☐ | Other |

b. Other Significant Conditions or Serious Illnesses (and when they were diagnosed):

c. Hospitalizations (reasons and dates):

d. Surgeries:

**3. Social History**

a. Smoking History: ☐ Never smoked

☐ Smoked intermittently
**Started:**
**Stopped:**
**Smoked what?** _____
**How much?** _____
**(e.g., packs/day)**

☐ Has stopped smoking
**Started:**
**Stopped:**
**Smoked what?** _____
**How much?** _____
**(e.g., packs/day)**

☐ Currently smoking
**Started:**
**Smokes what?** _____
**How much?** _____
**(e.g., packs/day)**

b. Other Pertinent Social History (e.g. drug or alcohol use, strenuous hobbies):

**D. Present Illnesses / Physical Examination** **(Please type or neatly print all responses.)**

1. Chief Complaints/Symptoms - as described by patient. Please comment on all "Yes" answers (e.g., describe frequency, duration, and/or severity of symptoms).

| Yes | No | | Comments |
|---|---|---|---|
| ☐ | ☐ | Sputum (daily?) | |
| ☐ | ☐ | Wheezing (daily?) | |
| ☐ | ☐ | Dyspnea (quantitate) | |
| ☐ | ☐ | Cough | |
| ☐ | ☐ | Hemoptysis | |
| ☐ | ☐ | Chest pain (inciting factor) | |
| ☐ | ☐ | Orthopnea | |
| ☐ | ☐ | Ankle edema | |
| ☐ | ☐ | Paroxysmal Nocturnal Dyspnea | |
| ☐ | ☐ | Other | |

(Indicate in D.4., below, any of the above symptoms manifested during the exam.)

**2. Other Complaints. (Include here the patient's description of any limitations in physical activities like walking, climbing, and lifting.)**

**3. Current Treatment (including medications):**

**4. Physical Findings: Based on your physical examination, provide a narrative statement listing all findings, especially those pertinent to the respiratory/pulmonary system and the cardiovascular system.**

**Height:** _____ (in inches and in stocking feet – no shoes)
**Weight:** _____ (lbs.)
**Findings (including respiratory/pulmonary symptoms):**

**5. Summary of Diagnostic Testing** - in the space below, check the applicable block(s) next to any test results **(including those conducted in conjunction with this physical exam)** which you reviewed and relied upon, at least in part, in reaching your medical assessments and conclusions - especially those on the next page. Be sure to show the date(s) of each test and summarize the results.

| | Dates | Summary of Results |
|---|---|---|
| ☐ **Chest X-ray** | | |
| ☐ **Vent Study (PFS)** | | |
| ☐ **Arterial Blood Gas** | | |
| ☐ **Other** | | |
| ☐ **Other** | | |

**6. Respiratory/Pulmonary Diagnosis(es): Identify the patient's chronic respiratory/pulmonary disease(s) or condition (s). Do not address the etiology of any diagnosed condition here; instead, address etiology in Section 7 below.**

**6a. Explain how you arrived at your diagnosis(es) in D.6. above. In particular, explain how the results of the diagnostic tests listed in D.5. above relate to your diagnosis(es). Attach additional sheets if necessary.**

**7. Etiology of Respiratory/Pulmonary Diagnosis(es): Describe the cause(s) of each respiratory/pulmonary diagnosis listed above; possible causes include occupational or environmental exposure, genetic predisposition, smoking, other, or unknown. In particular, describe the contribution of the patient's occupational dust exposure to his/her disease or condition. Explain how you arrived at your conclusion, including how the diagnostic tests listed in D.5. above relate to your opinion. Attach additional sheets if necessary.**

**8. Disability/Impairment and Cause: If the patient has chronic respiratory/pulmonary disease or condition, give your medical assessment on the following:**

**8a. Describe the degree of severity of the patient's respiratory/pulmonary impairment, particularly in terms of the extent to which the impairment prevents the patient from performing his/her current or last coal mine job of one year's duration (refer to Section B.1.a.) This is considered the miner's disability assessment. Attach additional sheets if necessary.**

**8b. Explain how you arrived at your disability assessment. In particular, explain how the results of the diagnostic tests listed in D.5. above relate to your conclusion. Attach additional sheets if necessary.**

**8c. If the patient has a respiratory/pulmonary disability or impairment, identify the cause(s) of the disability or impairment, especially with reference to the diagnoses listed in D.6. above. If there is more than one cause, give your estimate of the percentage or portion of impairment that can be attributed to each diagnosis (e.g. 50%, substantial, minimal, etc.). Explain how you reached your conclusions. Attach additional sheets if necessary.**

**9. Non-pulmonary Diagnosis: If the patient has any cardiac or other non-respiratory/pulmonary condition(s), indicate what the condition is and describe its impact on the patient's respiratory/pulmonary condition or impairment (if any), especially as it may affect his/her ability to perform coal mine work.**

## E. Physician Referral

Should the patient be referred to another physician for further evaluation? ☐ Y ☐ N Has referral been made ☐ Y ☐ N

For what reason?

## F. Physician's Signature

I certify that the information furnished is correct and that I am aware my signature attests to its accuracy. I am also aware that any person who willfully makes any false or misleading statement or representation in support of an application for benefits shall be guilty of a misdemeanor under 30 USC 941 and, on conviction, subject to a fine of up to $1,000, or imprisonment for up to one year, or both.

Signature: _____ **Date:** _____

(Physician's name should be typewritten on the front page of this form.)

**TWO FILING OPTIONS:**

**1. To file electronically, submit completed form to the COAL Mine Portal: https://coalmine.dol.gov**

**2. To file by mail, send completed form to: U.S. Department of Labor, OWCP/DCMWC, PO Box 8307, London, KY 40742-8307**

**For Further Information call TOLL FREE: 1-800-347-2502**

**Public Burden Statement**

We estimate that it will take an average of 40 minutes per response to complete this information collection, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and composing and reviewing the collection of information. If you have any comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, send them to the U.S. Department of Labor, Division of Coal Mine Workers' Compensation, 200 Constitution Avenue, N.W., Suite C3520-DCMWC, Washington, D.C. 20210. **DO NOT SEND THE COMPLETED FORM TO THIS OFFICE.**

**Privacy Act Notice**

In accordance with the Privacy Act of 1974, as amended (5 U.S.C. 552a), you are hereby notified that: (1) the Black Lung Benefits Act (BLBA) (30 U.S.C. 901 et seq.), as amended, is administered by the Office of Workers' Compensation Programs (OWCP) of the U.S. Department of Labor, which receives and maintains personal information, relative to this application, on claimants and their immediate families; (2) information obtained by OWCP will be used to determine eligibility for benefits payable under the BLBA; (3) information may be given to other government agencies, coal mine operators potentially liable for payment of the claim or to the insurance carrier or other entity which secured the operator's compensation liability, contractors providing automated data processing services to the Department of Labor; and representatives of the parties to the claim; (4) information may be given to physicians or other medical service providers for use in providing treatment, making evaluations and for other purposes relating to the medical management of the claim; (5) information may be given to the Department of Labor's Office of Administrative Law Judges, or other person, board or organization, which is authorized or required to render decisions with respect to the claim or other matters arising in connection with the claim; (6) information may be given to Federal, state or local agencies for law enforcement purposes, to obtain information relevant to a decision under the BLBA, to determine whether benefits are being or have been paid properly, and where appropriate, to pursue administrative offset and/or debt collection actions required or permitted by law; (7) disclosure of the claimant's or deceased miner's Social Security Number (SSN) or tax identifying number (TIN) on this form is voluntary, and the SSN and/or TIN and other information maintained by the OWCP may be used for identification and for other purposes authorized by law; (8) failure to disclose all requested information, may delay the processing of this claim or the payment of benefits, or may result in an unfavorable decision or reduced level of benefits; and (9) this information is included in a System of Records, DOL/OWCP-2 published at 81 Federal Register 25765, 25858 (April 29, 2016) or as updated and republished.

**Notice**

If you have a substantially limiting physical or mental impairment, Federal disability nondiscrimination law gives you the right to receive help from OWCP in the form of communication assistance, accommodation and modification to aid you in the claims process. For example, we will provide you with copies of documents in alternate formats, communication services such as sign language interpretation, or other kinds of adjustments or changes to account for the limitations of your disability. Please contact our office or the claims examiner to ask about this assistance.

**Note: Persons are not required to complete this collection of information unless it displays a currently valid OMB control number.**

**INSTRUCTIONS FOR BLACK LUNG PHYSICAL EXAMINATION**
**(GUIDE TO COMPLETING FORM CM-988)**

The enclosed Form CM-988, “Medical History and Examination for Coal Mine Workers' Pneumoconiosis,” is used by the U.S. Department of Labor to obtain the examining physician's findings with respect to the existence, severity, and cause of the miner's chronic respiratory or pulmonary disease, if any. The physical examination is part of a complete pulmonary evaluation that usually includes a chest x-ray, pulmonary functions study, and arterial blood gas test. Please note that this is a new form, replacing the previous version of the CM-988. There have been a number of minor revisions. It is important that you provide a response to each question or item in each section of the form, even if the only appropriate response is “N/A” (Not Applicable). Also, please pay close attention to:

**Block B.1. Coal Mine Employment - CME.**

Because total disability is defined as the miner's inability to perform his or her usual coal mine job (usually the miner's most recent job of at least one-year's duration), the examining physician must understand the physical requirements of the miner's coal mine employment. You must record the job title and describe the specific physical requirements of the miner's last coal mine job held for at least one year on Block B.1.a. In addition, we will provide you with Form CM-911a, “Employment History,” whenever possible. This form contains the miner's own account of his or her work history and is provided to assist you in making an informed medical evaluation. Only Blocks B.1.a. and B.1.d. need to be completed when we have provided you with the “Employment History” form. If we do not provide the “Employment History” form, and it is not available from the Black Lung District Office that authorized this examination, you must obtain a brief work history from the miner for entry in Blocks B.1. and B.2.

**Block D.4. Physical Findings.**

Please concentrate on reporting findings that may be relevant to the patient's respiratory/ pulmonary ability to perform his or her last coal mine work. Note any general findings you believe are important, such as blood pressure, temperature, and pulse. Also note any specific findings about the miner's extremities, thorax and lungs, heart, ENT, musculoskeletal structure, and abdomen that are relevant to your evaluation.

**Block D.6.a. Respiratory/Pulmonary Diagnosis(es).**

If you find that the patient has pneumoconiosis or any other respiratory/pulmonary condition, it is essential that you document the facts you have used to make this diagnosis. Please include relevant supporting information from the history, physical examination, chest imaging, and physiologic testing, as specifically requested. Your narrative should provide a complete rationale as to why you are diagnosing pneumoconiosis, particularly if your diagnosis is not clearly supported by the test results from Block D.5.

**Block D.7. Etiology of Respiratory/Pulmonary Diagnosis(es).**

Please describe the causes of each respiratory/pulmonary diagnosis above. Causes could include occupational or environmental exposures, genetic predisposition, personal habits, infectious agents, unknown, etc.

Please support your conclusion by citing the information obtained in your exam including exposure history, social history (e.g. smoking), chest imaging, test results and physical examination findings. Please describe the contribution of the miner's occupational dust exposure to his or her respiratory/pulmonary condition.

Note that the Department of Labor's regulations define pneumoconiosis not only as one of the lung diseases recognized by the medical community as pneumoconiosis, but also as any chronic respiratory/pulmonary disease or impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment. This definition includes such diseases as chronic obstructive pulmonary disease (COPD), emphysema, and chronic bronchitis when they arise out of coal mine employment.

**Block D.8. Disability/Impairment and Cause.**

a. Please describe the severity of any respiratory/pulmonary impairment that you diagnose. This impairment must then be compared to the exertional requirements of the miner's last coal mine job. You must reach one of two conclusions: (1) The patient ***is*** totally disabled for this last coal mine job due to the respiratory/pulmonary condition, or (2) he or she ***is not*** totally disabled and has the respiratory/pulmonary capacity to perform all the physical requirements of his or her last coal mine job. Do not simply diagnose a “mild,” “moderate,” or “severe” impairment, or cite the AMA Guides to Impairment class (e.g., Class 0-4) alone. You must also provide your reasoned opinion regarding whether the patient is able to perform the duties required in his or her last coal mine job.

b. Please explain your disability assessment with reference to the results of your examination and testing. In addition, if the miner's objective test results do not “qualify” to demonstrate total disability under the Department's pulmonary function or blood gas study guidelines, but you nevertheless diagnose total respiratory/pulmonary disability, please explain.

c. If you diagnose a respiratory/pulmonary disability, identify the cause(s) of the disability, including pulmonary or non-pulmonary causes. Please report the extent to which each of the diagnoses you listed in D.6. contributes to the miner's disability. You may use percentages, proportions, or narrative, but please be thorough and ensure that you have weighed the contribution of each diagnosis to the disability. Include citations for any other sources you used in reaching your conclusions.

**Block D.9. Non-pulmonary diagnosis.**

Please report any cardiac or other diagnosis that may affect the miner's exertional ability from a respiratory standpoint. Be sure to state the degree of impairment, if any, and explain if the symptoms are similar to those of a respiratory/pulmonary diagnosis.

**This form should be completed thoroughly to avoid the necessity of follow-up questions.**

Please note that the examination report form CM-988 is available in electronic, fillable PDF format from the DCMWC website at https://www.dol.gov/sites/dolgov/files/owcp/regs/compliance/cm-988.pdf. You may file the completed form through DCMWC's C.O.A.L. Mine web portal at https://coalmine.dol.gov or by mailing it to:
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