APPLICATION FOR CHRISTOPHER R. SLEZAK
FIRST RESPONDER PRESUMED COVERAGE FUND

Michigan Department of Labor and Economic Opportunity
Workers' Disability Compensation Agency
P.O. Box 30016, Lansing, MI 48909

1. NAME OF EMPLOYEE (Last, First, MI)			2. SOCIAL SECURITY NUMBER	3. DATE OF BIRTH
4. STREET NUMBER AND NAME			8. TAX FILING STATUS ☐ A. Single ☐ C. Married, Filing Joint ☐ B. Single, Head of Household ☐ D. Married, Filing Separate	
5. CITY	6. STATE	7. ZIP CODE		
			9. DATE OF DEATH (If Applicable)	
10. NAME OF DEPENDENTS			11. RELATIONSHIP TO EMPLOYEE	12. BIRTH DATE
13. NAME OF EMPLOYER			14. DATES OF EMPLOYMENT FROM: TO:	
15. FEDERAL I.D. NUMBER (If Known)			16. EARNINGS $ ☐ Hourly ☐ Weekly	
17. STREET ADDRESS			18. CITY	19. STATE / 20. ZIP CODE

21. ARE YOU CURRENTLY OR HAVE YOU EVER BEEN IN FULL-TIME ACTIVE SERVICE OF THIS EMPLOYER? ☐ YES ☐ NO
ARE YOU A CURRENT OR FORMER PART-TIME, PAID ON-CALL; VOLUNTEER OF THIS EMPLOYER? YES NO
ARE YOU A FORMER FOREST FIRE OFFICER/CRASH RESCUE OFFICER OF THIS EMPLOYER? YES NO

IF NO, PLEASE EXPLAIN:____________________
BRIEF JOB DESCRIPTION:____________________
NAME OF SUPERVISOR ____________ PHONE____________ EMAIL (if known)____________

22. IN THE COURSE OF YOUR EMPLOYMENT WITH THE FIRE DEPARTMENT/FIRE AUTHORITY WERE YOU EXPOSED TO THE HAZARDS INCIDENTAL TO FIRE SUPPRESSION, RESCUE, OR EMERGENCY MEDICAL SERVICES? ☐ YES ☐ NO

23. HAVE YOU FILED A CLAIM AGAINST THE EMPLOYER IN NUMBER 14? ☐ YES ☐ NO

24. HAVE YOU FILED AN APPLICATION FOR MEDIATION OR HEARING (WC104A) AGAINST THE EMPLOYER IN NUMBER 14? ☐ YES ☐ NO

25. HAVE YOU BEEN DIAGNOSED WITH RESPIRATORY TRACT, BLADDER, SKIN, BRAIN, KIDNEY, BLOOD, THYROID, TESTICULAR, PROSTATE, LYMPHATIC, OVARIAN, BREAST OR NON-HPV CERVICAL CANCER ☐ YES ☐ NO
IF YES, TYPE:
DATE OF INITIAL MEDICAL APPOINTMENT RELATED TO DIAGNOSIS:____________ DATE OF DIAGNOSIS:____________

26. FATHER ☐ ALIVE (AGE____) ☐ DECEASED (AGE_____) ☐ UNKNOWN CAUSE OF DEATH:____________ ☐ UNKNOWN
MOTHER ☐ ALIVE (AGE____) ☐ DECEASED (AGE_____) ☐ UNKNOWN CAUSE OF DEATH:____________ ☐ UNKNOWN

27. ARE YOU CURRENTLY OR HAVE YOU EVER BEEN A TOBACCO USER? If Yes, proceed to the following: ☐ YES NO
AT WHAT AGE DID YOU FIRST USE TOBACCO?____________
IF YOU HAVE QUIT, PLEASE PROVIDE DATE____________
PLEASE DESCRIBE TOBACCO USE____________
____

28. ARE YOU RECEIVING A PENSION? ☐ YES NO
IF YES, PLEASE ADVISE THE TYPE OF PENSION: REGULAR OR DISABILITY (circle one)
IF NO, HAVE YOU APPLIED FOR A PENSION? YES NO
HAS YOUR PENSION APPLICATION BEEN DENIED? ☐ YES NO

29. LIST THE NAMES AND ADDRESSES OF ALL DOCTORS, HOSPITALS AND OTHER HEALTH CARE PROVIDERS. (ATTACH A SEPARATE SHEET IF NECESSARY)				
NAME	ADDRESS (Street Number and Name)	CITY	STATE	ZIP CODE

30. HAVE YOU HAD ANY EMPLOYMENT SINCE THE DATE OF INJURY? ☐ YES ☐ NO
IF YES, LIST THE NAME AND ADDRESS OF THE EMPLOYER.

☐ THE MAKING OF THIS CLAIM CONSTITUTES A SUSPENSION OF MY CLAIM AGAINST MY EMPLOYER.

Making a false or fraudulent statement for the purpose of obtaining or denying benefits can result in criminal or civil prosecution, or both, and denial of benefits.

The submission of this application does not guarantee the right to benefits under the Workers' Disability Compensation Act.

SIGNATURE OF EMPLOYEE	TELEPHONE NUMBER	EMAIL ADDRESS	DATE

ATTORNEY IDENTIFICATION

NAME OF ATTORNEY	NAME OF LAW FIRM	ATTORNEY ID **P.**	
ADDRESS (STREET NUMBER AND NAME)	CITY	STATE	ZIP CODE
SIGNATURE OF ATTORNEY	TELEPHONE NUMBER	DATE	

LEO is an equal opportunity employer/program. Auxiliary aids, services and other reasonable accommodations are available upon request to individuals with disabilities.	AUTHORITY: Workers' Disability Compensation Act COMPLETION: Mandatory MCL 418.405 PENALTY: None

Please make sure you meet ONE of the following requirements before submitting this application:

1. Be a current member of a fully paid fire department or public fire authority and be compensated on a full-time basis.
2. Be a former full-time member of a fully paid fire department or public fire authority diagnosed on or after January 1, 2022.
3. Be a current or former part-time, paid on-call; volunteer member diagnosed on or after January 1, 2022.
4. Be a former forest fire officer/crash rescue officer diagnosed on or after January 1, 2022.

In addition, the first responder must also meeting ALL of the following criteria:

1. Been in service of the department or authority for at least 60 months.
2. Been diagnosed with any respiratory tract, bladder, skin, brain, kidney, blood, thyroid, testicular, prostate, lymphatic cancer, ovarian, breast or non-HPV cervical cancer
3. If diagnosed with ovarian, breast or non-HPV cervical cancer, the diagnosis must have been made on or after January 1, 2022.
4. Been exposed to the hazards incidental to fire suppression, rescue, or emergency medical services in the performance of his or her work-related duties.
5. Have applied for and done all things necessary to qualify for any pension benefits to which he or she may be entitled.