WORKERS' COMPENSATION FORM

PLEASE BRING THIS COMPLETED FORM WITH YOU TO YOUR APPOINTMENT WITH THE ATTORNEY.

INFORMATION ABOUT YOU

Name:____ Male or Female

Home address: ____

City: ________________________ State: _________ Zip code:______________

Home phone number: (_______) ________________

Work phone number: (_______) _________________

Cell phone number: (_______) __________________

Social Security number: _____-______-_______ Date of Birth:_________________

Marital status ________________________ Spouse's name:________________

Number of Children under 18:________

Child's Name:_______________________ Age______ Relationship____________

Child's Name:_______________________ Age______ Relationship____________

Child's Name:_______________________ Age______ Relationship____________

Child's Name:_______________________ Age______ Relationship____________

INFORMATION ABOUT YOUR EMPLOYMENT AT THE TIME OF INJURY

Name of Employer:____

Employer's address: ____

City: _______________ State: ______ Zip code: ________ Phone: (____) __________

Length of employment: _______ Start date: ___________________ Years: ______

Job title: ____

Job Duties: ____

Your immediate supervisor: ____

Number of hours per week you worked before the injury:

Regular: _______ Hourly rate: ________

Overtime hours per week: ____________

Gross earnings per week (before taxes): $_____________

Union?____________ If yes, which union and which local? _______________________

Did you have a second job at the time of your injury? Yes or No

If yes, with what company? ____

Was your employer aware of your second job? Yes or No

Gross earnings per week (before taxes) from your second job:______________________

Present employer, if different from above: _____________________________________

Name of your employer's workers' compensation insurance carrier at the time of your injury: ____

Address:______________________________________ City: _____________________

State: ___________ Zip code: ___________ Claim number: _______________________

Adjuster: _______________________________ Phone number: (_____) _____________

INFORMATION ABOUT YOUR INJURY OR ILLNESS

Date of injury: _____________ Time of day: ________________________ AM or PM

Location of accident (plant, office, etc.) ______________________________________

City: _______________ State: _________ County: _____________ Zip code: ________

Did you report the accident to your employer? Yes or No

If yes, when? _________ To Whom? __________ What is/was their position with your employer? ____________________ Did you report the accident in writing? Yes or No

Witnesses:____

____

____

Describe how you were injured: ____

____

____

____

____

What parts of your body were injured? (Please specify right, left, etc.) _______________

____

____

Did you have any broken bones from this accident? Yes or No

If yes, which bones were broken? ____

What physical complaints do you have currently? ________________________________

____

____

____

____

INFORMATION ABOUT YOUR MEDICAL TREATMENT

Did you go to the hospital because of this injury? Yes or No

Name of Hospital #1: ____

Complete mailing address: Street or P.O. Box _________________________

City: ___________________________________State: ______ Zip Code:_______

Telephone Number: ____

Inpatient Stays: Date admitted: _________________ Date released: ________

Reason for Inpatient Stay: ____

Treatment received at Inpatient stay: ___________________________________

Outpatient Visits: Dates ____

Reason for Outpatient Visit: ____

Treatment received at Outpatient Visit: ________________________________

Emergency Room Visits: Dates _______________________________________

Reason for ER Visit: ____

Treatment received at ER Visit: _______________________________________

Name of Hospital #2: ____

Complete mailing address: Street or P.O. Box ___________________________

City: ______________________________________State: ______ Zip Code:_______

Telephone Number: ____

Inpatient Stays: Date admitted: __________________ Date released: ________

Reason for Inpatient Stay: ____

Treatment received at Inpatient stay: ______________________________________

Outpatient Visits: Dates ____

Reason for Outpatient Visit: ____

Treatment received at Outpatient Visit: ___________________________________

Emergency Room Visits: Dates ____

Reason for ER Visit: ____

Treatment received at ER Visit: ____

Name of Hospital #3: ____

Complete mailing address: Street or P.O. Box ___________________________

City: ______________________________________State: ______ Zip Code:_______

Telephone Number: ____

Inpatient Stays: Date admitted: __________________ Date released: ________

Reason for Inpatient Stay: ____

Treatment received at Inpatient stay: ______________________________________

Outpatient Visits: Dates ____

Reason for Outpatient Visit: ____

Treatment received at Outpatient Visit: ___________________________________

Emergency Room Visits: Dates ____

Reason for ER Visit: ____

Treatment received at ER Visit: ____

Name and address of the doctors you have seen for this injury:

Name of Healthcare Provider #1: ____

Complete mailing address: Street or P.O. Box ___________________________

City: ______________________________________State:______ Zip Code:_______

Telephone Number: ____

Approximate Date you first saw this healthcare provider: _________________

Approximate Date you last saw this healthcare provider: _________________

Do you have another appointment scheduled to see this healthcare provider? If so, please list the date: ____

What was the reason for your last visit to this healthcare provider? _________

____

What treatment was received? _____________________________________

Name of Healthcare Provider #2: _____________________________________

Complete mailing address: Street or P.O. Box _______________________

City: _________________________________State: ______ Zip Code:_______

Telephone Number: ____

Approximate Date you first saw this healthcare provider: _________________

Approximate Date you last saw this healthcare provider: _________________

Do you have another appointment scheduled to see this healthcare provider? If so, please list the date: ____

What was the reason for your last visit to this healthcare provider? _________

____

What treatment was received? _____________________________________

Name of Healthcare Provider #3: ______________________________________

Complete mailing address: Street or P.O. Box _______________________

City: _________________________________State: ______ Zip Code:_______

Telephone Number: ____

Approximate Date you first saw this healthcare provider: _________________

Approximate Date you last saw this healthcare provider: _________________

Do you have another appointment scheduled to see this healthcare provider? If so, please list the date: ____

What was the reason for your last visit to this healthcare provider? _________

____

What treatment was received? ____

If you need more space to list additional Healthcare Providers please use a separate sheet of paper and list the same information that is requested above.

Did you receive Physical Therapy? Yes or No

If yes, where? ____

Have any of your doctors released you to return to work? Yes or No

If yes, which doctor:________________________________

Did he place any restrictions on you returning to work? Yes or No

If yes, what are the restrictions?____

____

Have you been released from active medical care? Yes or No

If not, form which doctors are you still receiving active treatment?

____

____

Do you have any prior injuries or illnesses? If so, please describe injury or illness and approximate date. ____

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<u>INFORMATION ABOUT YOUR WORKERS' COMPENSATION BENEFITS</u>

Did you lose any time from work because of your injury? Yes or No

If yes, how much time did you lose from work? __________________________________

From:_________________ To: __________________________

Did your employer or their insurance company pay you money for the time you missed? Yes or No

If yes, how much were you paid per check? __________ Are you still receiving payments? Yes or No

Were you placed on light-duty employment by your employer when you returned to work? Yes or No

If yes, what type of light duty were you given, and for how long? ____________________

____

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Is there anything else you would like to tell us about yourself? ______________________

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