

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, from 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. _____

INFORMATION ABOUT YOUR WORKERS' COMPENSATION BENEFITS

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? _____

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