For Office Use Only Apply for Hearing? _____

Reason_____ **Received:**_____

WORKER'S COMPENSATION INFORMATION SHEET

TODAY'S DATE: _____ **REFERRED BY:** _____

NAME: _____

ADDRESS: _____

PHONE: (_____) _____ **CELL:** (_____) _____ **SSN:** _____

Emergency Contact Phone: (_____) _____ **Date Of Birth:** _____

********** ACCIDENT INFORMATION **********

DATE of ACCIDENT: _____ LOCATION of ACCIDENT (County) _____

PART(S) of BODY INJURED: _____

HOW INJURY OCCURRED: _____

WERE YOU INJURED IN A GRADUAL MANNER ☐ OR BY A SUDDEN OCCURRENCE? ☐ Check One

DID YOU REPORT INJURY? YES ☐ NO ☐ To Whom & When?_____

DID YOU FILL OUT A FIRST REPORT OF AN ACCIDENT? YES ☐ NO ☐

DID YOU MISS WORK AS A RESULT OF THE ACCIDENT? YES ☐ NO ☐

If Yes, How Much?: _____ **Hourly Wage: $**_____ **Hours Per Week Worked:** _____

HOW LONG had you WORKED for this EMPLOYER BEFORE BEING INJURED? _____

DATE FIRST MEDICAL TREATMENT SOUGHT: _____

HAVE YOU INJURED THIS PART OF YOUR BODY BEFORE? YES ☐ NO ☐

IF YES, STATE HOW PREVIOUS INJURY OCCURRED: _____

********* EMPLOYMENT INFORMATION *********

EMPLOYER AT TIME OF INJURY: _____ PHONE:_____

ADDRESS: _____

YOUR JOB TITLE: _____

PERSON To CONTACT For WAGE INFORMATION: _____ PHONE: _____

DID YOU HAVE ANY OTHER JOBS AT THE TIME OF THE ACCIDENT? YES ☐ NO ☐

IF YES, WHERE? _____

WHAT WAS YOUR GROSS WEEKLY PAY AT THE OTHER JOB? _____

WORKER'S COMPENSATION CARRIER, ADDRESS & TELEPHONE: _____

_____

Has the Worker's Compensation CARRIER Paid Any of Your MEDICAL BILLS? YES ☐ NO ☐

HAVE YOU SIGNED ANY PAPERS FOR THE WORKER'S COMPENSATION CARRIER OR YOUR EMPLOYER REGARDING YOUR ACCIDENT YES ☐ NO ☐

HAVE YOU SPOKEN WITH THE INSURANCE CARRIER? YES ☐ NO ☐

Has the Worker's Compensation CARRIER TAPE RECORDED YOUR STATEMENT?

YES ☐ NO ☐

****** HOSPITAL / DOCTOR INFORMATION ******

NAMES AND ADDRESSES OF HEALTH CARE PROVIDERS (TO INCLUDE: DOCTORS, HOSPITALS, EMERGENCY TRANSPORT, TESTING CENTERS, THERAPY)

1 _____

2 _____

3 _____

4 _____

5 _____

6 _____

7 _____

8 _____

IS ANY PARTY OUTSIDE YOUR EMPLOYMENT RESPONSIBLE FOR YOUR INJURY?

YES ☐ NO ☐ IF SO, GIVE NAME, ADDRESS & TELEPHONE: _____

_____

Have you ever had a WORKMEN'S COMPENSATION CLAIM BEFORE? YES ☐ NO ☐

IF SO, GIVE DATE (S) And INJURY or INJURIES: _____

_____

_____

_____

_____

_____