



**WORKER'S COMPENSATION INFORMATION**

TODAY'S DATE \_\_\_\_\_ NAME \_\_\_\_\_  
DOB \_\_\_\_\_ SOCIAL SECURITY# \_\_\_\_\_  
HOME ADDRESS \_\_\_\_\_ HOME NUMBER \_\_\_\_\_  
EMPLOYER \_\_\_\_\_ EMPLOYER ADDRESS \_\_\_\_\_  
EMPLOYER'S NUMBER \_\_\_\_\_ SUPERVISOR'S NAME \_\_\_\_\_  
HUMAN RESOUC E CONTACT \_\_\_\_\_ SUPERVISOR'S DIRECT NUMBER \_\_\_\_\_  
DATE OF ACCIDENT \_\_\_\_\_ DID ANYONE WITNESS ACCIDENT? \_\_\_ YES \_\_\_ NO  
WAS THE INJURY REPORTED TO MANAGEMENT? \_\_\_ YES \_\_\_ NO  
TO WHOM WAS INJURY REPORTED? \_\_\_\_\_ WHEN? \_\_\_\_\_  
CHECK ONE:  FULL-TIME EMPLOYED  PART-TIME EMPLOYED  VOLUNTEER  NOT EMPLOYED  
HOW MANY DOCTORS HAVE YOU SEEN FOR THIS INJURY? \_\_\_\_\_  
DOCTORS' NAMES AND PHONE NUMBERS WHO HAVE TREATED YOU FOR THIS INJURY: \_\_\_\_\_

BRIEFLY GIVE DETAILS OF HOW ACCIDENT OCCURRED: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

BRIEFLY DESCRIBE YOUR SYMPTOMS SINCE YOUR ACCIDENT: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

HAVE YOU FILED A WORKER'S COMPENSATION CLAIM?  Y  N  
HAVE YOU REPORTED THIS INJURY TO YOUR EMPLOYER?  Y  N  
WERE YOU TREATED WHEN THE INJURY HAPPENED?  Y  N  
HAVE YOU MISSED WORK SINCE THIS INJURY OCCURRED?  Y  N  
DOES YOUR JOB REQUIRE FREQUENT LIFTING?  Y  N \_\_\_\_\_ LBS.  
HAVE YOU MISSED WORK DUE TO PRIOR INJURIES?  Y  N

DO NOT COMPLETE – OFFICE INFORMATION ONLY:  
WORKER'S COMPENSATION INSURANCE CARRIER: \_\_\_\_\_  
INSURANCE CARRIER'S ADDRESS: \_\_\_\_\_  
\_\_\_\_\_  
INSURANCE CARRIER'S PHONE NUMBER: \_\_\_\_\_  
WORKER'S COMPENSATION CLAIM NUMBER: \_\_\_\_\_  
SPECIFIC INSTRUCTIONS: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
NOTES: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_