WORKERS COMPENSATION INJURY REPORT

First Name:________________________ MI:_____ Last Name:______________________________________

Address:____ Male__ Female__ SSN #:___________________

City:____________________ State:_____ Zip:_________ Date of Birth:____________________________

Primary Phone:__________________________________ Cell/Secondary:___________________________

Present Employer:_______________________________

Address:____

City:____________________ State:_____ Zip:_________

Date(s) Employed:_______________________________

Your Occupation:________________________________

If injury occurred while employed elsewhere:

Employer:______________________________

Address:_______________________________

City:_________________ St:___ Zip:_______

Date(s) Employed:_______________________

Occupation:____________________________

WC Contact:____________________________

Phone:_________________________________

Contact Information for Workers' Comp (WC) Claim:

Employer Contact Name:__________________________ Telephone #:_____________________________

WC Insurance:___________________________________ WC Adjuster Name:_________________________

WC Claim#:_____________________________________ WC Insurance Phone #:______________________

We need copies of any Employer/Insurance workers' comp paperwork you were given.

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Accident/Injury Date & Time:_______________________ Date/time you first left work_______________

Where did the accident/injury take place?____

How long have you been off work?____

Does your employer know about the accident/injury?__________ When did you report it?_______________

Have you seen any other doctors/physical therapists/specialists:______ If yes, please list names/clinics:

____

If yes, was this a company doctor?______________ or private/primary care doctor?___________________

If yes, did you receive permission from insurance to change doctors?______ Do you have a referral? _______

If yes, what was the diagnosis?____

What treatment did you receive?____

Have you reported accident/injury to anyone else?__________ Whom?_____________________________

Did you obtain permission from your employer to see a doctor?__________________________________

Are you filing a claim under State or Federal Compensation Acts?_________________________________

Briefly explain how this accident/injury happened:

Describe your symptoms in detail:

Have you had similar problems before?_________ If yes, list details including dates & doctors/clinics seen:

Signature:____ Date:______________________

Revised 2/6/2017