

# WORKERS' COMPENSATION INFORMATION FORM

Date: \_\_\_\_\_ Referred By: \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Phone \_\_\_\_\_ Alt. Phone \_\_\_\_\_

Birthdate \_\_\_\_\_ SS# \_\_\_\_\_

Husband / Wife \_\_\_\_\_

Dependents \_\_\_\_\_ Birth Dates \_\_\_\_\_

Tax Filing Status: Single \_\_\_\_\_ Single Head of Household \_\_\_\_\_

Married Filing Separate \_\_\_\_\_ Joint \_\_\_\_\_

Liens: Medical \_\_\_\_\_ Medicare \_\_\_\_\_ Medicaid \_\_\_\_\_ Friend of Court \_\_\_\_\_

## Employment Information

Employer \_\_\_\_\_ Date Hired \_\_\_\_\_

Address of Employer \_\_\_\_\_

Type of Work \_\_\_\_\_ Working Now? \_\_\_\_\_

Rate of Pay \$ \_\_\_\_\_ Weekly Gross \$ \_\_\_\_\_

Supervisor / Foreman \_\_\_\_\_

City of Injury \_\_\_\_\_ Date of Injury \_\_\_\_\_

County \_\_\_\_\_

Job Description: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Fringe Benefits: Medical / Dental / Optical / Vacation / COLA / Profit Sharing / Disability \_\_\_\_\_

Type of Termination: Fired \_\_\_\_\_ Laid Off \_\_\_\_\_ Medical \_\_\_\_\_

Quit \_\_\_\_\_ Retired \_\_\_\_\_ Other \_\_\_\_\_

Reason for Termination \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

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**Benefits Received or Presently Receiving from Current Employer**

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Weekly Workers Compensation Amount Weekly \$ \_\_\_\_\_

Sick & Accident Ins.\$ \_\_\_\_\_ Week / Month Old Age SS\$ \_\_\_\_\_ Week / Month

Unemployment \$ \_\_\_\_\_ Week / Month Pension / Retire\$ \_\_\_\_\_ Week / Month

Disability Ins. \$ \_\_\_\_\_ Week / Month Self Ins.\$ \_\_\_\_\_ Week / Month

Profit Sharing \$ \_\_\_\_\_ Week / Month Wage Cont. Plan \$ \_\_\_\_\_ Week / Month

Regular Social Security \$ \_\_\_\_\_ SSD\$ \_\_\_\_\_

Retirement Pension \$ \_\_\_\_\_ Pending \_\_\_\_\_

60 Day Case : YES \_\_\_\_\_ NO \_\_\_\_\_

Dual Employment: YES \_\_\_\_\_ NO \_\_\_\_\_

W/C Insurance Carrier: \_\_\_\_\_

Adjuster: \_\_\_\_\_

Claim # \_\_\_\_\_

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**Injury Information**

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Date of Original Injury \_\_\_\_\_ Last Day Worked \_\_\_\_\_

Notice to Employer(date) \_\_\_\_\_ To Whom \_\_\_\_\_

Name & Address of  
Witnesses:

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Description of Incident that caused  
injury:

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Description of  
Injuries

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Returned to same employer:

Prior  
Injuries

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Emergency  
Medical

Treating Dr (S).

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Hospital  
Care

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Other Pending Cases:          Neg.          MVA          Employment          W/C         

**Past Work (last 15  
years)**

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Education:

Atty. Notes:

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