WORKER'S COMPENSATION

DATE ____________ SOURCE ____________ TAKEN BY ____________

NAME ____________ DOB ____________

ADDRESS ____________

TEL. HOME ____________ WORK ____________ CELL ____________

EMAIL ADDRESS ____________

S.S.N. ____________ M S W D SPOUSE'S NAME ____________ DEPENDANTS ____________

EMPLOYER ____________ DATE HIRED ____________

ADDRESS ____________ COUNTY ____________

OCCUPATION ____________ DEPT. ____________ WAGES ____________

MEDICARE ID # ____________ MEDICAID ID # ____________

SS INCOME AMT ____________ SS DISABILITY PAYMENTS ____________

HEALTH INSURANCE ____________ ID NUMBER ____________

PRIOR CLAIM ____________ DATE ____________

COURT ____________ ATTORNEY ____________ AWARD ____________

PRIOR CLAIM ____________ DATE ____________

COURT ____________ ATTORNEY ____________ AWARD ____________

PRESENT CLAIM ____________ DATE ____________

WHERE ____________

HOW ____________

MEDICAL ATTN. RECD. ____________

DATE RPTD ____________ STOPPED WORK ____________ RET. WORK ____________

NAME & TITLE OF PERSON REPORTED TO ____________

WC INSURANCE INFORMATION ____________

DOCTORS ____________

____

TEMP. PAID ____________ Per Week / Month PERM. PAID ____________ Per Week / Month

ORTHOPEDIC *NEUROLOGIC* *NEUROPSYCHOLOGICAL* *OTOLOGIC* *PULMONARY*

COMMENTS ____________

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OTHER ATTORNEYS CONSULTED ____________