WORKER'S COMP QUESTIONAIRE

Name: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Phone: _____ Birth Date: _____ Sex: _____ Married? _____

Occupation: _____

Employer's Name: _____

Employer's Address: _____ City: _____

State: _____ Zip Code: _____

Name of Employer's Insurance Company: _____

Claim Number: _____

Is your disability due to illness or accident? _____

Date and Time of Accident: _____ Date and Time Disability Began: _____

Date You First Became Ill or Accident Occurred: _____

How Long Have You Been Off Work: _____ What Date/Time Did You First Leave Work: _____

Where Did The Accident Take Place: _____

Does Your Employer Know About Your Accident: _____ When Did You Report It: _____

Do You Have Permission To See A Doctor: _____

Have You Seen A Medical Doctor About Your Case: _____ Their Name: _____

Are They A Company Doctor or Private Doctor: _____

What Was Their Diagnosis: _____

What Treatment Did They Give You: _____

Have You Made A Report To Anyone Else: _____ Whom: _____

Are You Filing A Claim Under State or Federal Compensation Acts: _____

Do You Have Other Insurance: _____ Whom: _____

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Explain in **EXACT DETAIL** how the accident happened:

Describe your symptoms in **DETAIL**:

Have you ever had similar trouble before? _____

If yes, state complete details including dates and name of doctors:

Signature: _____ Date: _____