

WORKERS COMP FORM

1. What was the date of the injury? _____
2. What time did the injury occur? _____
3. What is the name of your employer? _____
4. What is the street address of your employer? _____
5. What is the City, State, and Zip of your employer? _____
6. What is the name of your attorney? _____
7. What is the street address of your employer? _____
8. What is the City, State, and Zip of your attorney? _____
9. Please describe your incident in a few sentences: _____

10. Did you report the incident to your supervisor? _____
11. What is your Supervisor's name? _____
12. Did your employer send you to a doctor? If yes, please provide the doctor's name

13. Did you go to a doctor on your own? If yes, please provide the doctor's name

14. Are there any other problems that affect your employment?

15. Does your job cause you to favor one side of your body? _____
16. Before the injury, were you capable of performing equal work with others your age?

17. Have you injured this area before? -yes - no