



WORKERS' COMPENSATION FORM

NOTICE: If you were injured on the job, you must REPORT THE INJURY to your employer. Failure to do so will result in denial of any payment. In the event that your workers' compensation insurance will not cover, you are responsible for your bill. Thank you.

NAME _____ DATE OF BIRTH _____

ADDRESS _____ CITY _____ STATE _____ ZIP _____

SOCIAL SECURITY # _____ HOME PHONE _____ WORK PHONE _____

EMPLOYER _____ ADDRESS _____

Name of person you reported the injury to _____

Is this person your supervisor? Yes No If no, supervisor's name _____

Who referred you to our office? _____

Please explain how the accident happened _____

Date of present injury _____ Time _____

Did you feel pain immediately at the time of the injury? Yes No If yes, where? _____

If no, please state when you began to have pain and where. _____

Did you return to work following the injury? Yes No

When you reported the injury to your supervisor, were you instructed to see a particular doctor? Yes No

If yes, whom did you see? _____

How much time have you lost from work as a result of this injury? _____

Have you ever injured this area before? Yes No If yes, please indicate when, where, and how _____

Since this injury, are your symptoms improving? _____ getting worse? _____ the same? _____

AGREEMENT TO PAY IN THE EVENT THAT COMPENSATION IS DENIED:

In the event that I fail to prosecute the claim for workers' compensation for this illness or condition, or it is determined that the illness or condition is not a result of a compensable workers' compensation case, I hereby agree to pay this office's usual and customary fees for services rendered to me.

Date _____ Signature _____

Please do not write below this line.

This injury was verified by _____ on _____

Name of supervisor who verified the injury _____ Time of call _____