WORKER'S COMPENSATION'S INTAKE

DATE:_____ TELEPHONE #_____

NAME:_____ EMAIL:_____

ADDRESS:_____CITY:_____ZIP:_____

SOCIAL SECURITY #:_____DATE OF BIRTH:_____

EMPLOYER'S NAME:_____TELEPHONE #_____

ADDRESS:_____

YOUR OCCUPATION:_____DATE OF INJURY:_____

DESCRIBE YOUR JOB DUTIES:_____

WORKER'S COMPENSATION INSURANCE COMPANY:_____

ADDRESS:_____CITY:_____ZIP:_____

TELEPHONE #:_____

WHAT PART OF YOUR BODY WAS INJURED?_____

TIME YOU WERE INJURED:_____HOW DID IT OCCUR?_____

_____

TO WHOM DID YOU REPORT THE INJURY?_____WHEN:_____

NAME OF WITNESSES:_____

WAS YOUR INJURY CAUSED BY UNSAFE WORK PLACE? YES_____ NO_____

WAS A CLAIM FORM GIVEN TO YOU? YES___ NO___ IF SO, WHEN? _____

DID YOU RETURN THE COMPLETED FORM TO YOUR EMPLOYER? YES_____ NO_____

IF SO, WHEN? _____

WHAT WERE YOUR EARNINGS AT TIME OF INJURY?_____

WERE YOU ENTITLED TO AUTOMATIC RAISES OR COST OF LIVING INCREASES? IF SO,

EXPLAIN: _____

FIRST DAY OFF WORK:_____DATE RETURNED TO WORK_____

LIST ALL OTHER DATES THAT YOU WERE OFF WORK:_____

WERE YOU FIRED OR LAID OFF? YES_____NO_____ IF SO WHEN:_____

REASONS GIVEN:_____

HAVE YOU GIVEN A STATEMENT ABOUT YOUR INJURY OTHER THAN YOUR DOCTOR? ____

YES ___NO IF YES, IDENTFY: _____

ARE YOU INTERESTED IN RETURNING TO THE SAME JOB? ___ YES ___NO

ARE YOU INTERESTED IN A MODIFIED POSITION WITH SAME EMPLOYER? ___YES ___NO

MEDICAL TREATMENT RECEIVED

NAME OF DOCTOR	ADDRESS AND PHONE NUMBER	DATE LAST SEEN
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

WHO SENT YOU TO THESE DOCTORS? _____

ARE YOU CONTINUING TO RECEIVE TREATMENT? YES_____ NO_____

HAVE YOU BEEN EXAMINED BY A QME DOCTOR FROM A LIST PROVIDED TO YOU FROM THE STATE OF CALIFORNIA? YES_____ NO_____

WHO? _____WHEN? _____

DO YOU HAVE ANY OTHER MEDICAL CONDITIONS (EXAMPLE: HEART DISEASE, ARTHRITIS, OSTEOPENIA, DIABETES, AND HIGH BLOOD PRESSURE)? ____YES ____NO

INSURANCE

DID YOUR EMPLOYER GIVE YOU A DOCUMENT REQUESTING THAT YOU DESIGNATE A TREATING DOCTOR PRIO TO YOUR INJURY? _____

DOES YOUR EMPLOYER OFFER HEALTH INSURANCE? _____

WHO PAYS FOR IT?_____

HAVE YOU RECEIVED ANY NOTICE FROM YOUR EMPLOYER REGARDING A MEDICAL PROVIDER NETWORK? YES_____NO_____

HAVE YOU RECEIVED ANY LETTER FROM YOUR EMPLOYER OR INSURANCE COMPANY REGARDING CHANGE OF MEDICAL CARE? YES_____NO_____

WORKER'S COMPENSATION BENEFITS RECEIVED

WEEKLY RATE: _____TOTAL AMOUNT RECEIVED: _____

DATE FIRST RECEIVED: _____ DATE LAST RECEIVED: _____

HAS THERE BEEN ANY UNREASONABLE DELAY IN RECEIVING ANY WORKER'S COMPENSATION BENEFITS? IF SO, WHAT? _____

_____

HAVE YOU RECEIVED STATE DISABILITY (EDD)? YES___ NO___

HAVE YOU RECEIVED UNEMPLOYMENT BENEFITS? YES___ NO___

HAVE YOU RECEIVED ANY OTHER BENEFITS? YES___ NO___

IF YES, WHAT TYPE: _____

HAS YOUR EMPLOYER PAID YOUR MEDICAL BILLS? YES___ NO___

DO YOU HAVE MEDI-CAL? YES___ NO___

ARE ANY OF YOUR BILLS PAID BY PRIVATE INSURANCE? YES___ NO___

HAVE YOU EVER BEEN INVOLVED IN ANY OTHER ACCIDENTS OR SUFFERED OTHER INJURIES? YES___ NO___

DATES:	PART OF BODY:	HOW DID IT OCCUR:	FULLY RECOVERED:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

LIST ALL DOCTORS / HOSPITALS SEEN FOR EACH OF THE ABOVE INJURIES/ILLNESS:

DATES:	DOCTORS / HOSPITALS:	ADDRESSES:
_____	_____	_____
_____	_____	_____
_____	_____	_____

UNION

DO YOU BELONG TO A UNION? YES_____NO_____

NAME: _____ADDRESS:_____

TELEPHONE # _____UNION REP.:_____

EMPLOYMENT HISTORY FOR PAST ONE YEAR

INCLUDING CURRENT EMPLOYER

EMPLOYER:_____TITLE:_____

ADDRESS:_____

TELEPHONE #:_____ EARNINGS:_____

DATES OF EMPLOYMENT: _____

EMPLOYER: _____ TITLE:_____

ADDRESS:_____

TELEPHONE # _____ EARNINGS: _____

DATES OF EMPLOYMENT: _____

HAVE YOU SEEN AN ATTORNEY ABOUTH THIS PROBLEM? YES_____ NO_____

IF YES, PROVIDE NAME ADDRESS, AND PHONE #.

_____

WHO REFERRED YOU OR HOW WERE YOU REFERRED TO THIS OFFICE? _____

FOR OFFICE USE ONLY

____ Adverse Party files checked by (initial) _____

____Open ____CAO ____ Hold