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**Workers' Compensation Claim Form (Please complete)**

Print, type, or write clearly, and answer all the questions to the best of your ability. Complete answers will allow our office to better help you in the processing of your claim. If you need additional space, attach a separate sheet. Thank you.

If completing online, use Tab button to navigate form.

Who referred you to contact our office?

[CLICK HERE TO BEGIN](#)

Full Name: \_\_\_\_\_

Address: \_\_\_\_\_

City/ State/ Zip: \_\_\_\_\_

City

State

Zip

Phone Number (including area code): \_\_\_\_\_

Message No. (if different from Phone above): \_\_\_\_\_

Date of Birth (dd/mm/yy): \_\_\_\_\_

SSN: \_\_\_\_\_

Education (completed): \_\_\_\_\_

(Including any degrees, certifications/certificates, licenses, trade/vocation schooling, etc.)

Do you smoke? Yes or No If yes, how many packs per day? \_\_\_\_\_

Height: Weight: lbs

What is your martial status? Married Separated Divorced Single (Check one)

If you are married, how do you file your income taxes? Jointly Separately

Do you have any children, under the age of 18? Yes No

If "yes", please list their names, date of births, and if you claim them on your taxes.

_____	DOB: _____	Yes	No
_____	DOB: _____	Yes	No
_____	DOB: _____	Yes	No
_____	DOB: _____	Yes	No

Do you have a lien with the Friend of the Court? Yes No

If yes, in what county? \_\_\_\_\_

**Employers Full Name and Address:**

**Date of Injury:**

\_\_\_\_\_

\_\_\_\_\_

**Started When:**

\_\_\_\_\_

\_\_\_\_\_

**Last Day Worked:**

\_\_\_\_\_

**List your job position(s) & give complete description:**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**What was your hourly wage at the time of your injury? Or salary?**

\_\_\_\_\_

**How many hours per week at the time of your injury?**

\_\_\_\_\_

**Days per week?**

\_\_\_\_\_

**Do you have health insurance, or other fringe benefits? If yes, with whom?**

\_\_\_\_\_

\_\_\_\_\_

**Are you on "Medicare"?**    Yes    No

**If not, have you applied or will you be eligible for it soon?**    Yes    No

**Are you on "Medicaid"?**    Yes    No

**Did or are you receiving any work comp wage loss benefits?**    Yes    No

If "yes", what was/is your comp rate?

\_\_\_\_\_

**Have you had a prior and/or present work injury claim?**    Yes    No

If "yes", when, what was the injury to, who represented you, & what was the outcome?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**List the name(s), address(s), & phone number(s) of the doctors/healthcare facilities that you been for treatment in relation to your disabilities.**

\_\_\_\_\_  
1. Name

\_\_\_\_\_  
2. Name

\_\_\_\_\_  
1. Address

\_\_\_\_\_  
2. Address

\_\_\_\_\_  
1. Phone

\_\_\_\_\_  
2. Phone

\_\_\_\_\_  
3. Name

\_\_\_\_\_  
4. Name

\_\_\_\_\_  
3. Address

\_\_\_\_\_  
4. Address

\_\_\_\_\_  
3. Phone

\_\_\_\_\_  
4. Phone

**\*\*If there is additional doctors please attach a separate sheet.**

**List what medications you are presently on.**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Have you had any other employment since the time of your injury?**      Yes      No

If "yes", list the name, address of employer, and dates of employment:

\_\_\_\_\_  
\_\_\_\_\_

**Were you working for any other employer at the time of your injury?**      Yes      No

If "yes", please provide the name, address, and time frame of your employment:

\_\_\_\_\_

**Have you drawn any short term or long term disability benefits from this employer, or from any other source?**      Yes      No

If "yes", what exactly, what was the time frame, and how much was received:

\_\_\_\_\_

**Enter any additional information here:**

**Your work history over the last 15 years is very important, please complete the Work History Form the best to your ability.**

**Thank you for your cooperation.**