WORK-RELATED INJURY/ILLNESS QUESTIONNAIRE

Please fill in the answers to the following questions in connection with your injury/illness and return the form to us promptly.

Claim # _____ **Employer** _____

1. Name _____ **2. Date of Birth** _____

3. Address _____ **City** _____

State _____ **Zip Code** _____ **4. Home Phone** ( ) _____

5. Date of Hire _____ **6. Occupation** _____

7. Weekly Wage $ _____ **8. Work Days** ☐Mon ☐ Tues ☐Wed ☐Thurs ☐Fri ☐Sat ☐Sun

9. Date and Time of Accident _____

11. Location of Accident ***(STREET, ADDRESS)*** _____

12. Description of Accident _____

13. What part(s) of body injured _____

14. Date you reported this accident _____ **15. To whom did you report this accident?** _____

16. Witness ***(IF ANY)*** _____ **17. Name of your Supervisor** _____

18. Name of doctor/hospital who initially treated you for this injury _____

19. Date of FIRST treatment _____ **20. Date of LAST treatment** _____

21. Are you still under medical care? ☐ YES ☐ NO **If YES, name of doctor last treated you** _____

22. Did you stop work due to injury? ☐ YES ☐ NO **If YES, date last worked** _____

23. Did you receive wages while you were out due to this incident? ☐ YES ☐ NO

24. Did you return to work after the injury? ☐ YES ☐ NO **If YES, date returned to work** _____

25. At the time of this injury, were you employed by any one else? ☐ YES ☐ NO

If yes, please give name and address of other employer: _____

_____

26. Have you been treated for a prior medical condition? ☐ YES ☐ NO

If yes, please give details including name and address of doctor/ hospital who treated you:

_____

_____

27. Was the prior medical condition work related? ☐ YES ☐ NO

Date of injury: _____ **Name of employer at the time of injury** _____

If yes, please give details including name and address of doctor/ hospital who treated you:

_____

_____

Date: _____ **Signature:** _____