WORKERS COMPENSATION

DATE: _____

CLIENT'S NAME: _____

ADDRESS: _____

PREVIOUS ADDRESS: _____

EMAIL ADDRESS: _____

TELEPHONE: CELL _____ HOME: _____

WORK: _____

DATE OF BIRTH: _____ AGE: _____ SSN: _____

EMPLOYER (AS LISTED ON PAYSTUB): _____

EMPLOYER'S ADDRESS: _____

PAY RATE: _____ HOURS WORKED WEEKLY: _____

BONSUSES GIVEN: _____ ANY OTHER WAGES/COMPENSATION: _____

WERE YOU WORKING A SECOND JOB ON THE DATE OF THE ACCIDENT? _____

2ND EMPLOYER (AS LISTED ON PAYSTUB): _____

2ND PAY RATE: _____ 2ND HOURS WORKED WEEKLY: _____

WHEN DID YOU BEGIN EMPLOYMENT WITH THIS COMPANY? _____ DATE

OF ACCIDENT: _____ COUNTY IN WHICH ACCIDENT OCCURRED: _____ TO

WHOM WAS ACCIDENT REPORTED? _____ WHEN

WAS ACCIDENT REPORTED? _____

TIME MISSED FROM WORK: _____

DESCRIPTION OF ACCIDENT:

_____

_____

_____

EXPLAIN INJURY (BODY PARTS AFFECTED):

_____

_____

_____

WITNESSES, IF ANY: _____

EMPLOYER'S WORKERS' COMPENSATION CARRIER: _____

ADJUSTER: _____

CLAIM NO.: _____ TELEPHONE NUMBER: _____

LIST EVERYWHERE YOU HAVE BEEN FOR TREATMENT:

EMS:_____

HOSPITAL:_____

OTHER:_____

_____

NAME OF YOUR FAMILY DOCTOR(S) FOR THE PREVIOUS 10 YEARS AND ADDRESS(ES): (IF NONE, IF YOU GET A COLD, WHERE DO YOU GO):

_____

_____

HOW LONG TREATING/YEAR OF FIRST TREATMENT_____

HEALTH INSURANCE COMPANY AND ADDRESS: _____

_____

LIST PREVIOUS WORKERS COMPENSATION CLAIMS: EMPLOYER, BODY PARTS INJURED AND DATE:

_____
_____
_____

HAVE YOU EVER HAD AN INJURY OR HAD TREATMENT TO THE SAME BODY PART THAT YOU INJURED IN THIS ACCIDENT? IF SO, EXPLAIN WHEN AND WHERE AND WHY YOU WERE TREATED:

_____
_____
_____
_____

HAVE YOU EVER BEEN GIVEN A DISABILITY OR IMPAIRMENT RATING TO <u>ANY</u> BODY PART? IF SO, WHEN, BY WHICH DOCTOR AND TO WHICH BODY PART?

_____
_____
_____

HAVE YOU BEEN MADE AN OFFER TO SETTLE THIS CLAIM? IF SO, HOW MUCH?

_____
_____

HOW WERE YOU REFERRED TO THE HAYES LAW FIRM? _____

IS THERE A THIRD PARTY CLAIM? _____YES OR _____ NO