

**WORKERS' COMPENSATION QUESTIONNAIRE**

CLAIMANT INFORMATION:

NAME \_\_\_\_\_ S.S.# \_\_\_\_\_

Address \_\_\_\_\_  
\_\_\_\_\_

Telephone Number \_\_\_\_\_ Birthdate \_\_\_\_\_

Name of Spouse \_\_\_\_\_

Name and address and telephone number of close friends or relatives who would  
always know your whereabouts \_\_\_\_\_

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EMPLOYER INFORMATION:

Company Name: \_\_\_\_\_

Address \_\_\_\_\_  
\_\_\_\_\_

Telephone Number \_\_\_\_\_

Name and job title of immediate supervisor \_\_\_\_\_  
\_\_\_\_\_

DATE OF INJURY \_\_\_\_\_ TIME OF ACCIDENT \_\_\_\_\_

LOCATION OF ACCIDENT (including county) \_\_\_\_\_  
\_\_\_\_\_

Compensation Insurance Carrier \_\_\_\_\_

If Claimant is other than injured party, list name, address and age and relationship  
to injury (deceased) party \_\_\_\_\_

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Claimant's description of how accident occurred \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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Was your accident caused in whole or in part by the use of any piece of defective machinery or equipment? Yes \_\_\_\_\_ No \_\_\_\_\_

If so, explain \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Was your accident caused in whole or in part by carelessness, or negligence of persons other than your fellow employees? Yes \_\_\_\_\_ No \_\_\_\_\_

Explain \_\_\_\_\_

\_\_\_\_\_

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WITNESSES TO YOUR ACCIDENT:

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

Address and telephone number \_\_\_\_\_

Name of company works for \_\_\_\_\_

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

Address and telephone number \_\_\_\_\_

Name of company works for \_\_\_\_\_

Have you given a statement regarding your claim to the company, their insurance adjuster, attorney or others? Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, give details \_\_\_\_\_  
\_\_\_\_\_

If a time clock used on job, were you punched in? Yes \_\_\_\_\_ No \_\_\_\_\_

If no time clock on job, give name of timekeeper and method of keeping employees time on job \_\_\_\_\_  
\_\_\_\_\_

NOTICE:

Did you give notice of your injury to the company? Yes \_\_\_\_\_ No \_\_\_\_\_

Name of person to whom you gave notice \_\_\_\_\_

1. Give details, time, place and witnesses to whom you gave notice of your injury \_\_\_\_\_

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

2. If you did not give notice personally to the company of your injury, state who did.

Give details \_\_\_\_\_

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

WAGE INFORMATION:

Are your wages paid: Weekly \_\_\_\_\_ Monthly \_\_\_\_\_ Semi-monthly \_\_\_\_\_

Hourly \_\_\_\_\_

Rate of pay: \$ \_\_\_\_\_ per \_\_\_\_\_

Were you receiving this same rate of pay for at least 13 weeks prior to the accident?

Yes \_\_\_\_\_ No \_\_\_\_\_

If you had not worked for the company for 13 weeks prior to the accident, what was the average weekly pay for other employees with your same job classification? \$ \_\_\_\_\_

Per week.

When did you first lose time off your job due to your injury? \_\_\_\_\_

Are you still off the job due to your injuries as of the date of this report?

Yes \_\_\_\_\_ No \_\_\_\_\_

If you have returned to work, state the date you returned \_\_\_\_\_

YOUR INJURIES:

State in detail all injuries received as a result of this accident \_\_\_\_\_

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Names and addresses of all treating physicians for this injury

Name \_\_\_\_\_ Address \_\_\_\_\_

Name \_\_\_\_\_ Address \_\_\_\_\_

Name \_\_\_\_\_ Address \_\_\_\_\_

What medical treatment have you received in connection with your accident and injury

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What did the doctor(s) say about you returning to work? \_\_\_\_\_

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As a result of your injury, what kind of physical restrictions has your doctor(s) placed you under? \_\_\_\_\_

That you have placed on yourself \_\_\_\_\_

**HISTORY:**

Name all employers which you have ever worked for and how long (give dates)

Describe all the job duties that were involved in the jobs you held in the previously disclosed occupations (e.g. manual labor requiring lifting) \_\_\_\_\_

Educational level (including any occupational training) \_\_\_\_\_

Medical – List here all illnesses or accidents you sustained, either before or since your Accident \_\_\_\_\_

**PRIOR ACCIDENTS AND INJURIES:**

List all prior accidents or injuries (give details) \_\_\_\_\_

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MISCELLANEOUS:

Have you been unemployed since your accident? \_\_\_\_\_

Have you been fired from your job? \_\_\_\_\_

If so, have you sought other employment? \_\_\_\_\_

If so, with what results? \_\_\_\_\_

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Miscellaneous or additional information you feel that is important concerning your claim

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Have you ever filed any workers' compensation claim prior to this one, or have you ever drawn workers' compensation benefits? If so, when \_\_\_\_\_

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Has claimant applied for social security? \_\_\_\_\_