STROW LAW LLC

INCIDENT INFORMATION SHEET – WORKERS' COMPENSATION

CLIENT INFORMATION Date________________________________

Client Name:

Mr. Ms. or Mrs. Spouse's full name, if married: __________________________

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____

Address City State/Zip Code

Home # _____________________ Work # ______________________

Cell # ________________________

E-Mail at home _______________________ E-Mail at work ___________________________

Date of Birth ___________ Social Security # ___________________

Driver's License # _____________________

Emergency Contact: Name: __________________________

Address: __________________________________

Home # _____________ Work# ________________Cell# _____________

Email: _________________________

IF YOU HAVE DEPENDENT CHILDREN, PLEASE COMPLETE THE FOLLOWING:

Name/Age: _________________________ Name/Age: _________________________

Name/Age: _________________________ Name/Age: _________________________

EMPLOYMENT INFORMATION

Employer:

____

Name Address

Your position or title: ____

Supervisor's Name: ____

Rate of Pay: $ __________ per hour or $ ___________________ yearly salary

How many hours do you normally work per week? ____________

Do you work overtime? Yes ____ No ____ Is it mandatory? Yes ____ No ____

When did you first become employed? ____

Did you work for a second employer at the time of the accident? Yes ____ No ____

If yes, please complete the following:

Employer:

____

Name   Address

Your position or title: ____

Supervisor's Name: ____

Rate of Pay: $ __________ per hour   or $ ___________________ yearly salary

How many hours do you normally work per week? ____________

Do you work overtime? Yes ____ No ____   Is it mandatory? Yes ____ No ____

When did you first become employed? ____

WORK ACCIDENT INFORMATION

What was the date of accident? ____________________ Time of accident? ____________________

In which city/town/state where you injured? ____________________

Did you report your accident to a supervisor? Yes ____ No ____

If yes, what date did you report? ____________________ Was notice in writing? ____ Orally? ____

UNDERSTANDING OF HOW THE INCIDENT OCCURRED:

____

____

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____

____

WITNESSES

Were there independent witnesses to the accident? Yes ____ No ____

Please list the following with respect to any independent witnesses:

NAME: ____ Phone Number:_____________________

Address:____

NAME: ____ Phone Number:____________________

Address:____

WORK STATUS

Have you missed any work as a result of the accident? Yes ____ No ____

Dates missed from work: ________________________ to ________________________

________________________ to ________________________

Are you currently working? Yes ____ No ____

Were you, or are you now, on light duty status? Yes ____ No ____

BENEFIT INFORMATION

Did you receive temporary total disability compensation after the accident? (Work Comp payments)

Yes ____ No ____

If yes, what dates did you receive benefits for?

________________________ to ________________________

________________________ to ________________________

What was/is the rate of pay for your workers' compensation checks? __________________________

Name of Workers' Compensation Insurance Carrier:

____

Agent/Adjuster:

____

Telephone Number: __________________________ Fax Number: _______________________________

Policy Number (if known): ____________________ Claim Number: ______________________________

Did you receive short-term or long-term disability payments (occupational benefit) after the accident?

Yes ____ No ____

If yes, what dates did you receive benefits for?

________________________ to ________________________

________________________ to ________________________

What was/is the rate of pay? __________________________

Name of Short-Term/Long-Term Disability Insurance Carrier:

____

Agent/Adjuster:

____

Telephone Number: __________________________ Fax Number: _______________________________

Policy Number (if known): ____________________ Claim Number: ______________________________

YOUR WORK-RELATED INJURIES

Please describe any and all aches, complaints, discomforts and disabilities, as a result of accident related injuries, in detail:

____

____

____

Did you go to the hospital? Yes ____ No ____

Name of Hospital: ____

Did you go by ambulance? Yes ____ No____

Name of Ambulance Service ____

Did they take x-rays? Yes _____ No ______ Did they take MRI's? Yes _____ No ______

HAVE YOU SEEN A DOCTOR SINCE THE DATE OF THE ACCIDENT, OTHER THAN AT THE EMERGENCY ROOM? Yes ____ No ____

If yes, please list all doctors and medical facilities: Name, address and telephone number:

____

____

____

____

Doctors/Medical Facilities Continued:

____

____

____

HEALTH INSURANCE

DO YOU HAVE HEALTH INSURANCE? IF YES, PLEASE COMPLETE THE FOLLOWING:

Name/Address of Insurance Carrier:

____

PPO, HMO, Medicaid, Medicare, other (please circle one)

Name of Policy Holder:

____

Group Number, if known:

____

Are you on Medicare or Medicare eligible? Yes ____ No ____

If yes, do you have Part D prescription drug coverage? Yes ____ No ____

Do you receive Public Aid/Medicaid? Yes ____ No ____

PRIOR ACCIDENTS OR INCIDENTS FOR ALL CLIENTS

(Please DO NOT leave blank, if none, so state)

DATE: __________________________

NATURE OF ACCIDENT OR INCIDENT/INJURIES (work related, auto, medical negligence?)

____

____

REFERRAL INFORMATION

How were you referred to us? (Circle any applicable) ________________________________

I am a previous client Office sign Web Site Radio TV Billboard Friend (please see below)
Physician (please see below) Phonebook Other____________________

If phonebook: name of book_____________________________

Name/address/phone of person who referred you:

____