WORK RELATED INJURY HISTORY

Name:_____ Today's Date:_____

PRESENT INJURY:

Date of the injury:_____ Time of the Injury_____ [ ] AM [ ] PM

Describe in detail how the Injury happened in your own words _____

_____

_____

_____

_____

_____

_____

If you need more room, please feel free to use the back of this page. Please check this box [ ] if you use the back of this page.

Was the work being done at the time of injury within your normal work duties? [ ] No [ ] Yes

Describe in detail your normal everyday work activities: (EX: Lifting include the # of pounds, if you lift above your head, if you lift from the floor, are you sitting at a desk all day on a phone or typing, looking at a computer, driving all day)

_____

_____

_____

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_____

If you need more room, please feel free to use the back of this page. Please check this box [ ] if you use the back of this page.

Have you had any time loss from work? [ ] No [ ] Yes, If yes, how long?_____

Are you currently working? [ ] No [ ] Yes Are your working with restrictions? [ ] No [ ] Yes If so what are they…….

_____

If you are **not** working, when was the last day you worked? _____

Prior to the accident, were you able to work on an equal basis with other your age? [ ] Yes [ ] No, If no, please explain

_____

_____

Since the accident, have your symptoms? [ ] Gotten Better [ ] Stayed the Same [ ] Gotten Worse

Has a workers' compensation claim been filed? [ ] No [ ] Yes If yes, what date? _____

WORK RELATED INJURY HISTORY, page 2

Name:_____ Today's Date:_____

EMPLOYER/EMPLOYMENT INFORMATION:

Name of Employer at time of Injury:_____

Occupation:_____ Employer's Phone Number:_____

Employers Address:_____

Did you report the incident to your employer? [ ] No [ ] Yes Date you reported the injury_____

Was an incident report completed? [ ] No [ ] Yes Name of person reported to_____

How long have you been working with this company? _____

Was a pre-employment examination performed? [ ] Yes [ ] No

PREVIOUS WORK INJURY HISTORY:

Have you ever applied for workers compensation benefits before? [ ] Yes [ ] No

Date:_____ Reason:_____

_____

Was there time loss from work? [ ] Yes [ ] No State of degree of recovery_____

Date:_____ Reason:_____

_____

Was there time loss from work? [ ] Yes [ ] No State of degree of recovery_____

If you need more room, please feel free to use the back of this page. Please check this box [ ] if you use the back of this page.

INSURANCE INFORMATION:

Employers Managing MCO for BWC:_____

BWC Claim #:_____

Attorney Name:_____

Attorney Firm:_____

Phone #:_____