Dr. Jennifer Carrasco • Dr. Alan Furman • Dr. Ross Ginsberg

WORKER'S COMPENSATION INFORMATION

PLEASE FILL OUT COMPLETELY

NAME: ________________________________ Date: ___/___/___

EMPLOYER NAME: ________________________________
EMPLOYER ADDRESS: ________________________________
____
EMPLOYER PHONE#: ________________NAME OF CONTACT: ____________

ON THE DATE OF INJURY WHAT WAS YOUR JOB TITLE OR DESCRIPTION?
____

ON THE DATE OF INJURY WHAT WERE YOUR USUAL WORK ACTIVITIES?
____

WORKER'S COMP. INSURANCE CARRIER: ____________________
CARRIER ADDRESS: ________________________________
____
CARRIER PHONE#: ________________ CLAIM#: ____________
WHERE DID ACCIDENT OCCUR? ____________________
DESCRIPTION OF ACCIDENT: ____________________
____
____
DATE AND TIME OF ACCIDENT: ____________________

ATTORNEY NAME: ________________ PHONE#: ____________
ARE YOU PRESENTLY WORKING? ____YES ____NO
DATE LAST WORKED? ________________
HAVE YOU MISSED ANY WORK? ____YES ____NO HOW MANY DAYS? ________
DESCRIBE YOUR CURRENT CONDITION (INCLUDE ALL SYMPTOMS):
____
____
HAVE YOU HAD THIS INJURY BEFORE? ____YES ____NO
IF YES, EXPLAIN: ________________________________
DID YOU GO TO HOSPITAL? ____YES ____NO BY AMBULANCE? ____YES ____NO
HAVE YOU SEEN ANY OTHER DOCTORS FOR THIS INJURY? ____YES ____NO
IF YES, NAME AND ADDRESS: ____________________
____
HAVE YOU FILLED OUT ALL NECESSARY PAPERWORK (ACCIDENT/INJURY REPORT) WITH YOUR EMPLOYER? ____YES ____NO