WORKERS COMPENSATION CLIENT INFORMATION SHEET

Obtain Copies of: Driver's License ____ Health Ins. Card ____ Pay-Stubs ____

Soc. Sec. Card ____ Other Identification Card ____ Forms/Docs from WC ____

Name: _____ Soc. Sec#: _____

Address: _____ Telephone: _____

_____ Alt. Telephone: _____

Date of Birth: _____ Email: _____

Age: _____ Marital Status: _____

Social Media: _____

Accident Information

Date of Injury: _____ Date Employer Notified: _____

County of Accident: _____ How Notice Was Given: _____

Supervisor's Name: _____ Who Notice Was Given To: _____

_____

Employer Name: _____ Address: _____

_____ _____

Dates of Employment: _____ Last Day Worked: _____

Pay Rate at Time of Injury: _____ TTD Amount: _____

Overtime Pay Rate: _____ Position Held: _____

Benefits Provided by Employer:

Health Insurance: _____ Cost to Employee_____

Vehicle: _____ Disability Insurance: _____

Life Insurance: _____ 401(k): _____

Location of Accident: _____

_____

_____

_____

Description of Accident:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Body Part(s) Injured: _____

_____

Was Safety Equipment Provided? Was it used? _____

_____

Witnesses

Name	Relationship	Address	Phone #

Other Employment at the Time of Injury

Name of Employer	Location	Dates of Employment	Position Title	Avg. Hours/Week	Pay Rate

Benefits Provided by Employer(s) at Time of Injury:

Health Insurance: _____ Cost to Employee: _____

Vehicle: _____ Disability Ins.: _____

Life Ins.: _____ 401(K): _____

Post-Injury Employment

Name of Employer	Address	Dates of Employment	Position Title	Pay Rate

15-Year Employment History

Name of Employer	Location	Dates of Employment	Position Title

Education Info

Highest Grade Completed: _____ Last School Attended: _____

Special Ed: _____ Read: _____ Write: _____ Military: _____

Specialized Training: _____

Insurance Information

Health Insurance Company: _____ Telephone #: _____

Address: _____ Policy #: _____

_____

Policy Holder: _____ Relationship: _____

Medical Information

Taken by EMS: _____ Admitted to Hospital: _____

_____ _____

Assistive &/or Prosthetic Devices: _____

Pre-Existing Injuries: _____

_____

_____

Drug Abuse: Yes / No Alcohol Abuse: Yes / No Treatment: Yes / No

Type of Drug(s)/Alcohol & Name of Treatment Facility(s): _____

_____

Criminal Background: _____

_____

_____

Other Workers' Comp. Claims or Lawsuits Filed: _____

_____

_____

_____

Medical Providers

Please provide the medical providers you have seen in relation to this accident.

Provider Name	Facility	Location	Treatment Dates	Approved by Carrier?

Medications

Please provide the medications you have taken as a result of the accident.

Name of Medication	Dosage	Prescribing Physician	Side Effects	Currently Taking?

Workers' Comp Claim Information

Adjuster's Name: _____ Phone #: _____

Email Address: _____ Fax #: _____

Nurse Case Manager: _____ Phone #: _____

WCC File #: _____ Carrier File #: _____

TTD Start Date: _____ TTD End Date: _____

Impairment Ratings: _____

_____

Hearing Scheduled: Yes / No Hearing Requested: Yes / No Hearing Attended: Yes / No

Hearing Date/Location: _____

Hearing Outcome: _____

Previous Attorney Name: _____

Third-Party Info

Third-Party Eligible: Yes / No Statute of Limitations: _____

Address: _____ Third-Party Defendants: _____

_____ _____

WCC Notice of 3rd Party Action (Date of Service): _____

How did you hear about us?

Attorney Current/Former Client Family/Friend Reputation Website Yellow Pages

Other: _____

Notes