

STATEMENT OF THE INJURED

NAME: _____ MARRIED/SINGLE _____

ADDRESS _____ TELEPHONE _____

SOCIAL _____ DATE OF BIRTH _____ M/FM _____

HEIGHT/WEIGHT _____ RIGHT/LEFT HANDED _____

DEPENDENTS (NAME/AGE) _____

EMPLOYER _____ OCCUPATION _____

DATE OF HIRE _____

DATE OF ACCIDENT _____ PLACE OF ACCIDENT _____

TIME OF ACCIDENT: _____ am/pm

DESCRIBE THE ACCIDENT IN DETAIL, WHAT YOU WERE DOING, WHAT HAPPENED:

DESCRIBE YOUR INJURY: _____

NAME/ADDRESSES OF WITNESSES/PERSONS HAVING KNOWLEDGE: _____

NAME OF PHYSICIAN ARE/HAVE SEEN: _____

HIS ADDRESS/PHONE: _____

DATE OF FIRST VISIT: _____

FOLLOW UP TREATMENT _____

DIAGNOSIS _____

EXCUSED FROM WORK/ HOW MANY DAYS _____

MODIFIED WORK GIVEN/ WHAT RESTRICTIONS _____

HISTORY:

ANY PREVIOUS ACCIDENTS OR INJURIES (work or otherwise) PLEASE GIVE
DETAILS _____

DO YOU HAVE ANY SERIOUS ILLNESSES, PLEASE EXPLAIN _____

PERSONAL PHYSICIAN'S NAME, ADDRESS, PHONE: _____

INJURED EMPLOYEE

DATE