

Workers' Comp New Claim

First Name: _____ Last Name: _____

Today's Date: _____ Date of Injury: _____

Place of Employment: _____ Phone#: _____

Address: _____

Contact Person: _____ Phone #: _____

Job Title: _____ Full-time Part-Time

Job Description: _____

State how the injury occurred: _____

List present complaints: _____

Are you currently working? Yes No

Have you missed any time from work? Yes No If so, how much? _____

If so have you returned to work? Yes No Date Returned: _____

Have you been seen by any other doctors for this condition? Yes No

If so, who? _____

What insurance company will be handling the claim (please include mailing address)? _____

What is the claim number? _____

Adjuster Name: _____ Adjuster Phone#: _____