LAW OFFICES OF GREGORY W. HARBISON

WORKER'S COMPENSATION QUESTIONNAIRE

DATE OF FIRST INITIAL CONSULTATION: _____

INTERVIEWER: _____

DATE OF ACCIDENT: _____

STATUTE OF LIMITATION DATE: _____

ATTORNEY REFERRAL OR ASSOCIATED: _____

PERSONAL INFORMATION

CLAIMANT: _____

STREET AND MAILING ADDRESS:

_____

_____

(PLEASE PROVIDE ALL TELEPHONE NUMBERS THAT YOU CAN BE REACHED INCLUDING NAME OF PERSON WE CAN CONTACT IN CASE OF EMERGENCY)

TELEPHONE: _____

_____

_____

SOCIAL SECURITY NUMBER: _____

OCCUPATION AND TITLE AT TIME OF ACCIDENT:

_____

AVERAGE WEEKLY WAGE AT TIME OF ACCIDENT: _____
(**PROVIDE CHECK STUBS OR W-2 FORMS**)

DATE OF BIRTH: _____ RACE: _____SEX: _____

ARE YOU MARRIED_____ DIVORCED_____ SINGLE _____

NAME OF SPOUSE:_____

PLACE OF EMPLOYMENT: _____

NAME AND AGE OF ALL DEPENDENTS LIVING IN YOUR HOME:
_____

_____

****

EMPLOYER INFORMATION

NAME OF EMPLOYER: _____

MAILING ADDRESS:_____

STREET ADDRESS: _____

COUNTY WHERE INJURY OCCURRED: _____

WORKERS COMPENSATION INSURANCE CARRIER & ADDRESS, NAME OF ADJUSTER:
_____

_____

CASE MANAGER NURSE NAME, ADDRESS AND PHONE NUMBER:
_____

HAS THIS CASE BEEN PREVIOUSLY FILED WITH THE COMMISSION BY ANOTHER ATTORNEY, IF SO: PLEASE STATE THE NAME OF THE ATTORNEY AND DATE FILED WITH THE COMMISSION:
_____

_____

****

COMPLETE ACCIDENT INFORMATION

1. EXACT DATE OF INJURY: _____

2. TIME OF INJURY: _____

3. NATURE OF WORK IN WHICH CLAIMANT WAS ENGAGED AT THE TIME OF THE INJURY OR ILLNESS:

_____
_____
_____

4. DESCRIPTION OF ACCIDENT OR ILLNESS AND HOW IT HAPPENED:

_____
_____
_____

5. ACCURATELY DESCRIBED THE PART OR PARTS OF BODY INVOLVED OR INJURED, OR TYPE OF OCCUPATIONAL DISEASE:

_____
_____
_____

6. DATE EMPLOYER FIRST NOTIFIED OF INJURY OR ILLNESS AND NAME AND TITLE OF PERSON NOTIFIED:

_____
_____
_____

7. NAME AND ADDRESS OF WITNESSES:

_____
_____
_____

8. NAMES AND ADDRESSES OF ATTENDING PHYSICIANS AND HOSPITALS WITH DATES OF MEDICAL TREATMENT RENDERED. PLEASE LIST IN CHRONOLOGICAL ORDER. (**Please give full correct names and addresses**.)

DATE:	NAME OF DOCTOR & HOSPITAL & ADDRESS	REFERRED BY:
_____	_____	_____
_____	_____	_____
_____	_____	_____

_____ _____ _____

_____ _____ _____
_____ _____ _____

_____ _____ _____

LIST TREATMENTS BY THE DOCTORS TO INCLUDE THERAPY, XRAYS, MRI'S, ETC.

_____

_____

_____

_____

_____

9. WAS MEDICAL TREATMENT PAID BY EMPLOYER: _____

10. ARE THEY NOW PAYING FOR MEDICAL TREATMENT: _____

11. COMPENSATION HAS _____ HAS NOT_____ BEEN FOR.

IF PAID FROM _____ TO _____ AT THE RATE OF $_____.

A. PERIOD OF TEMPORARY DISABILITY: _____
B. DATE OF MMI: _____
LIST THE DOCTOR THAT RELEASED YOU: _____
C. DATE ABLE TO RESUME EMPLOYMENT: _____
D. NATURE, DEGREE AND EXTENT OF PERMANENT DISABILITY: _____
_____
E. LOSS OF WAGE EARNING CAPACITY: _____
_____

12. INJURY DID _____ DID NOT_____ RESULT IN DEATH. DATE OF DEATH:
_____

NAME, ADDRESS, DATE OF BIRTH AND RELATIONSHIP OF EACH CLAIMANT WHO WAS DEPENDENT AND FOR WHOM CLAIM IS MADE IS LISTED ON EXHIBIT 'A' AND ATTACHED HERETO, AND MADE A PART HEREOF BY REFERENCE.

13. ARE PENALTIES DEMANDED: YES _____ NO _____

IF YES, WHY: _____

_____

14. OTHER MATTES IN DISPUTE ARE AS FOLLOWS:

_____

_____

15. ARE YOU NOW EMPLOYED OR ARE YOU STILL UNDER PHYSICIAN CARE:

_____

_____

16. IF YOU ARE EMPLOYED NOW, GIVE THE FULL NAME, ADDRESS AND TELEPHONE NUMBER OF YOUR EMPLOYER, IF NOT THE EMPLOYER IN QUESTION FOR THIS CLAIM, THE AMOUNT OF WAGES YOU ARE NOW EARNING, SUPERVISOR, JOB TITLE, HOURS WORKED EACH WEEK:

NAME OF EMPLOYER & SUPERVISOR	WAGES	JOB TITLE	DATES OF EMPLOYMENT	HOURS WORKED

17. IF NOT EMPLOYED, PLEASE LIST ALL DATES THAT YOU HAVE BEEN OFF WORK INCLUDING DAYS THAT YOU HAD TO MISS WORK DUE TO THE INJURY:

_____

_____

18. IF YOU WERE RELEASED TO RETURN TO WORK, DID YOU CONTACT THE EMPLOYER FOR AVAILABILITY OF JOB? IF YES, PLEASE THE NAME AND TITLE OF THE PERSON YOU CONTACTED AND THE DATE OF SUCH CONTACT:

_____

_____

19. WAS THERE A JOB AVAILABLE?_____

20. IF NO JOBS AVAILABLE, HAVE YOU ATTEMPTED TO SEEK OTHER EMPLOYMENT? IF SO, PLEASE LIST ALL NAMES AND ADDRESSES OF PLACES CONTACTED INCLUDING THE PERSON YOU CONTACTED AND THEIR JOB TITLE AND THE REASON FOR NOT HIRING.

_____

_____

_____

_____

21. YOUR INCOME FOR THE PAST THREE YEAR PRIOR TO THE DATE OF THE ACCIDENT:_____

_____

22. WHAT YOU HAVE EARNED SINCE THE DATE OF THE ACCIDENT UNTIL THE CURRENT DATE:

_____

_____

23. WORK RECORD FOR THE PAST TEN YEARS PRECEDING THE ACCIDENT AND THE AMOUNT YOU MADE AT EACH JOB, WHY YOU LEFT, NAME OF SUPERVISOR.

NAME OF EMPLOYER	WAGES	JOB TITLE	LENGTH OF EMPLOYMENT	REASON FOR LEAVING
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

_____ _____ _____ _____ _____

_____ _____ _____ _____ _____

_____ _____ _____ _____ _____

_____ _____ _____ _____ _____

24. ANY PRIOR CLAIMS OR INJURIES OF ANY DESCRIPTION, INCLUDING PRIOR WORKERS COMPENSATION INJURIES, AUTOMOBILE ACCIDENTS, ETC. LIST THE DEFENDANT, DATE AND INJURY:

_____

_____

_____

_____

25. ANY CRIMINAL CONVICTIONS. IF SO, PLEASE LIST THE CONVICTION, COURT FILED IN, AND THE OUTCOME OF SAID CONVICTION:

_____

_____

26. ARE YOU DRAWING SOCIAL SECURITY, HAVE YOU EVER DRAWN SOCIAL SECURITY, HAVE YOU APPLIED FOR SOCIAL SECURITY BENEFITS.

_____

_____

IF NOT, LIST ANY TIME PERIODS WHICH YOU HAVE BEEN UNABLE TO WORK: DOCTOR WHO HAD YOU OFF WORK:

_____

_____

27. HAVE YOU FILED FOR UNEMPLOYMENT BENEFITS, IF YES, WHEN, AND WERE YOU ABLE TO DRAW UNEMPLOYMENT BENEFITS.

_____

_____

28. LIST ALL LAY WITNESSES THAT YOU WILL CALL IF THIS CASE PROCEEDS TO A LITIGATED MATTER:

_____

_____

_____

29. IF NOT PAID, LIST ALL BILLS THAT ARE OUTSTANDING OR YOU HAVE PAID (PROVIDE A RECEIPT): (THESE NEED TO BE KEPT CURRENT AND PROVIDED TO THIS OFFICE)

NAME:	AMOUNT:	WHETHER PAID:	WHO PAID OR UNPAID

_____

_____

_____

_____

_____

_____

_____
SIGNATURE OF CLAIMANT

_____
SIGNATURE OF INTERVIEWER