

# WORKER'S COMPENSATION'S QUESTIONNAIRE

DATE: \_\_\_\_\_ EMAIL: \_\_\_\_\_

NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ ZIP: \_\_\_\_\_

SOCIAL SECURITY #: \_\_\_\_\_ TELEPHONE # \_\_\_\_\_

EMPLOYER'S NAME: \_\_\_\_\_ TELEPHONE # \_\_\_\_\_

ADDRESS: \_\_\_\_\_

YOUR OCCUPATION: \_\_\_\_\_ DATE OF INJURY: \_\_\_\_\_

DESCRIBE YOUR JOB DUTIES: \_\_\_\_\_

WORKER'S COMPENSATION INSURANCE COMPANY: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ CITY: \_\_\_\_\_ ZIP: \_\_\_\_\_

TELEPHONE #: \_\_\_\_\_

WHAT PART OF YOUR BODY WAS INJURED? \_\_\_\_\_

TIME YOU WERE INJURED: \_\_\_\_\_ HOW DID IT OCCUR? \_\_\_\_\_

TO WHOM DID YOU REPORT THE INJURY? \_\_\_\_\_ WHEN: \_\_\_\_\_

NAME OF WITNESSES: \_\_\_\_\_

WAS YOUR INJURY CAUSED BY UNSAFE WORK PLACE? YES \_\_\_\_\_ NO \_\_\_\_\_

WAS A CLAIM FORM GIVEN TO YOU? YES \_\_\_ NO \_\_\_ IF SO, WHEN? \_\_\_\_\_

DID YOU RETURN THE COMPLETED FORM TO YOUR EMPLOYER? YES \_\_\_\_\_ NO \_\_\_\_\_

IF SO, WHEN? \_\_\_\_\_

WHAT WERE YOUR EARNINGS AT TIME OF INJURY? \_\_\_\_\_

FIRST DAY OFF WORK: \_\_\_\_\_ DATE RETURNED TO WORK \_\_\_\_\_

LIST ALL OTHER DATES THAT YOU WERE OFF WORK: \_\_\_\_\_

WERE YOU FIRED OR LAID OFF? YES \_\_\_\_\_ NO \_\_\_\_\_ IF SO WHEN: \_\_\_\_\_

REASONS GIVEN: \_\_\_\_\_

## **MEDICAL TREATMENT RECEIVED**

DOCTORS: \_\_\_\_\_ DOCTOR: \_\_\_\_\_

ADDRESS: \_\_\_\_\_ ADDRESS: \_\_\_\_\_

PHONE: \_\_\_\_\_ PHONE: \_\_\_\_\_

WHO SENT YOU TO THESE DOCTORS? \_\_\_\_\_

LAST DAY OF TREATMENT: \_\_\_\_\_

ARE YOU CONTINUING TO RECEIVE TREATMENT? YES \_\_\_\_\_ NO \_\_\_\_\_

HAVE YOU BEEN EXAMINED BY A QME DOCTOR FROM A LIST PROVIDED TO YOU FROM THE STATE OF CALIFORNIA? YES \_\_\_\_\_ NO \_\_\_\_\_

WHO? \_\_\_\_\_ WHEN? \_\_\_\_\_

## **INSURANCE**

DID YOUR EMPLOYER GIVE YOU A DOCUMENT REQUESTING THAT YOU DESIGNATE A TREATING DOCTOR PRIOR TO YOUR INJURY? \_\_\_\_\_

DOES YOUR EMPLOYER OFFER HEALTH INSURANCE? \_\_\_\_\_

WHO PAYS FOR IT? \_\_\_\_\_

HAVE YOU RECEIVED ANY NOTICE FROM YOUR EMPLOYER REGARDING A MEDICAL PROVIDER NETWORK? YES \_\_\_\_\_ NO \_\_\_\_\_

HAVE YOU RECEIVED ANY LETTER FROM YOUR EMPLOYER OR INSURANCE COMPANY REGARDING CHANGE OF MEDICAL CARE? YES \_\_\_\_\_ NO \_\_\_\_\_

**WORKER'S COMPENSATION BENEFITS RECEIVED**

WEEKLY RATE: \_\_\_\_\_ TOTAL AMOUNT RECEIVED: \_\_\_\_\_

DATE FIRST RECEIVED: \_\_\_\_\_ DATE LAST RECEIVED: \_\_\_\_\_

HAS THERE BEEN ANY UNREASONABLE DELAY IN RECEIVING ANY WORKER'S COMPENSATION BENEFITS? IF SO, WHAT? \_\_\_\_\_

HAVE YOU RECEIVED STATE DISABILITY (EDD)? YES \_\_\_ NO \_\_\_

HAVE YOU RECEIVED UNEMPLOYMENT BENEFITS? YES \_\_\_ NO \_\_\_

HAVE YOU RECEIVED ANY OTHER BENEFITS? YES \_\_\_ NO \_\_\_

IF YES, WHAT TYPE: \_\_\_\_\_

HAS YOUR EMPLOYER PAID YOUR MEDICAL BILLS? YES \_\_\_ NO \_\_\_

DO YOU HAVE MEDI-CAL? YES \_\_\_ NO \_\_\_

ARE ANY OF YOUR BILLS PAID BY PRIVATE INSURANCE? YES \_\_\_ NO \_\_\_

HAVE YOU EVER BEEN INVOLVED IN ANY OTHER ACCIDENTS OR SUFFERED SIMILAR INJURIES? YES \_\_\_ NO \_\_\_ IF YES, WHEN: \_\_\_\_\_

TYPE OF INJURY: \_\_\_\_\_ BENEFITS RECEIVED: \_\_\_\_\_

**UNION**

DO YOU BELONG TO A UNION? YES \_\_\_ NO \_\_\_

NAME: \_\_\_\_\_ ADDRESS: \_\_\_\_\_

TELEPHONE # \_\_\_\_\_ UNION REP.: \_\_\_\_\_

**EMPLOYMENT HISTORY FOR PAST ONE YEAR INCLUDING CURRENT EMPLOYER**

EMPLOYER: \_\_\_\_\_ TITLE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

TELEPHONE #: \_\_\_\_\_ EARNINGS: \_\_\_\_\_

DATES OF EMPLOYMENT: \_\_\_\_\_

EMPLOYER: \_\_\_\_\_ TITLE: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

TELEPHONE # \_\_\_\_\_ EARNINGS: \_\_\_\_\_

DATES OF EMPLOYMENT: \_\_\_\_\_

HAVE YOU SEEN AN ATTORNEY ABOUTH THIS PROBLEM? YES \_\_\_\_\_ NO \_\_\_\_\_  
IF YES, PROVIDE NAME ADDRESS, AND PHONE #.

WHO REFERRED YOU OR HOW WERE YOU REFERRED TO THIS OFFICE?

<b>FOR OFFICE USE ONLY</b>		
___	Adverse Party files checked by (initial)	___
___	Open	___
___	CAO	___
___	Hold	___