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