STATUTE OF LIMITATIONS:_____

LINDELL & LAVOIE, LLP
WORKERS COMPENSATION CASE INFORMATION

File No./Attorney:_____

Sign up Date: _____

Date of Loss: _____

PERSONAL DATA

Name _____ Marital status_____

Home address_____ Spouse_____

_____ Phone_____

_____

Home phone _____ Work phone_____

Maiden name aka _____ Cell phone_____

Children or parents_____

Address_____

Phone_____

DOB_____ Age_____

SSN_____ DLN_____ State_____

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EMPLOYMENT

Employer (where you were injured) _____

Address_____ Phone_____

_____

Job title_____ Wage on date of injury $_____

Hours/week worked_____ Overtime rate/hours_____

Was this job seasonal/construction?_____ Union?_____ Apprentice?_____

Are you still employed with this company?_____ If no, when did you leave and why?

_____

- Did you have a second job on the date of your injury? _____ If yes, where?

Name _____

Address_____ Phone_____

_____ Supervisor_____

What was the weekly gross income of 2nd job $_____

- What are the full names and addresses, start and end dates and gross weekly income for all employers you have worked for since your injury? _____

_____

_____

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INJURY

Date(s) of injury_____

What part(s) of your body was injured?_____

How did the injury happen?_____

_____

_____

Was the injury reported? If yes, to whom?_____

Were there witnesses to the accident? If yes, who?_____

Were you injured at a location other than where you normally work?_____ If yes, explain_____

Have you had similar injuries or previous work-related injures before? _____ If so, when, where, describe injuries_____

_____

_____

- Were you injured by a product (a machine or other device)?_____

  A. Who owned the product?_____

  B. Who maintained or supplied the product?_____

  C. Have there been any changes or alterations to the original product by anyone?_____

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MEDICAL TREATMENT

Treating medical providers in chronological order:

1. Name_____ Type/dr._____

   Address_____ # of visits_____

   _____ Phone_____

2. Name_____ Type/dr._____

   Address_____ # of visits_____

   _____ Phone_____

3. Name_____ Type/dr._____

   Address_____ # of visits_____

   _____ Phone_____

4. Name_____ Type/dr._____

   Address_____ # of visits_____

   _____ Phone_____

What is the doctors opinion about your injury?_____

_____

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INSURER

Wiorkers' Compensation insurance carrier for employer_____

Address_____ Phone_____

_____ Adjuster_____

Claim No._____

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COMPENSATION/BENEFITS

Have you received any weekly benefits from the wc insurance company?_____

Have you been paid any permanent partial disability benefits?_____ How much $_____

Since the injury have you received any other type of benefits (welfare, unemployment, disability insurance or social security)_____

Has the insurance company paid your medical bills?_____

Has your personal health insurance carrier been paying your medical bills related to the injury?_____ If yes, what is the name, address & policy number of your health insurance?_____

Has the wc insurance company sent you to one of their doctors yet?_____ If so, when and what doctor did you see?_____

Have you received a denial notice?_____ When?_____

Have you received a MMI report?_____ When?_____

Do you have a rehabilitation counselor/QRC?_____

Name_____ Phone_____

- **Other notes**_____

_____

_____

_____