LINDELL & LAVOIE, LLP WORKERS' COMPENSATION CASE INFORMATION	**STATUTE OF LIMITATIONS:** **SOURCE:**
	Type of File:
	Attorney:
	Sign up Date:
	Date of Loss:

PERSONAL DATA

Name:	Marital Status:
Home address:	Spouse:
	Phone:
	Work Phone:
	Email:
Maiden Name:	Children or parents:
Address:	Phone:
DOB: Age:	DLN: State:
SSN:	Restrictions/endorsements:
OK to disclose?	
Emergency Contact:	Phone:
Address:	Alt Phone:

EMPLOYMENT

Employer:	Work Phone:
Address:	Job Title:
Job description:	Date of Hire:
	Union? Apprentice? Seasonal?
Rate of pay $ /hour hrs/week	Salary:
Commission:	Gross weekly wage:
Supervisors name:	Overtime rate/hours:
Are you still employed with this company? _____ If no, when did you leave and why?	
Other employment/income:	Gross weekly wage:
Time lost from work:	NF paying:
Other employment/income:	Gross weekly wage:
Time lost from work:	NF paying:

INJURY

Date:	Time:
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 injuries before? If so, when, where, describe the 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?

MEDICAL INFORMATION

Injuries (in order of severity):

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:	
5. Name:	Type/Dr.:
Address:	# of visits:
Phone:	
6. Name:	Type/Dr.:
Address:	# of visits:
Phone:	

What is the doctors opinion about your injury?

INSURERS

Workers' Compensation insurance carrier for employer:	
Address:	
File/Claim No.:	
Contact:	Phone:

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 types of benefits (welfare, unemployment, disability insurance or social security)?
Has your personal health insurance carrier been paying your medical bills related to the injury? If yes, what is the name, address, and policy number of your health insurance? Name: Policy Number: Address:	
Has the wc insurance company sent you to the 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
