

ROBERT W. BLUE, D.C.

DARBOY FAMILY CHIROPRACTIC, S.C.

WORKER'S COMPENSATION INFORMATION

TODAY'S DATE _____ NAME _____
 DOB _____ SOCIAL SECURITY# _____
 HOME ADDRESS _____ HOME NUMBER _____
 EMPLOYER _____ EMPLOYER ADDRESS _____
 EMPLOYER'S NUMBER _____ SUPERVISOR'S NAME _____
 HUMAN RESOUC E CONTACT _____ SUPERVISOR'S DIRECT NUMBER _____
 DATE OF ACCIDENT _____ DID ANYONE WITNESS ACCIDENT? ___ YES ___ NO
 WAS THE INJURY REPORTED TO MANAGEMENT? ___ YES ___ NO
 TO WHOM WAS INJURY REPORTED? _____ WHEN? _____
 CHECK ONE: FULL-TIME EMPLOYED PART-TIME EMPLOYED VOLUNTEER NOT EMPLOYED
 DOCTORS' NAMES AND PHONE NUMBERS WHO HAVE TREATED YOU FOR THIS INJURY: _____

BRIEFLY GIVE DETAILS OF HOW ACCIDENT OCCURRED: _____

BRIEFLY DESCRIBE YOUR SYMPTOMS SINCE YOUR ACCIDENT: _____

- HAVE YOU FILED A WORKER'S COMPENSATION CLAIM? Y N
- HAVE YOU REPORTED THIS INJURY TO YOUR EMPLOYER? Y N
- WERE YOU TREATED WHEN THE INJURY HAPPENED? Y N
- HAVE YOU MISSED WORK SINCE THIS INJURY OCCURRED? Y N
- DOES YOUR JOB REQUIRE FREQUENT LIFTING? Y N _____ LBS.
- HAVE YOU MISSED WORK DUE TO PRIOR INJURIES? Y N

DO NOT COMPLETE - OFFICE INFORMATION ONLY:

WORKER'S COMPENSATION INSURANCE CARRIER: _____
 INSURANCE CARRIER'S ADDRESS: _____
 INSURANCE CARRIER'S PHONE NUMBER: _____
 WORKER'S COMPENSATION CLAIM NUMBER: _____
 SPECIFIC INSTRUCTIONS: _____
 NOTES: _____