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 RESOUCE 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:_____

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