

WORK RELATED ACCIDENT

WELCOME



WORK RELATED ACCIDENT

Date & Time of Accident: _____ a.m. _ p.m.

Was your accident directly related to your work? Yes _ No

Briefly describe the events that occurred just before and during your accident: _____

Give the address where accident occurred: (if other than employer's address) _____

Was anyone else present during your accident? Yes _ No

Did you report your accident to you your employer? Yes _ No

What recommendations did your employer make just after your accident? _____

Has this type of accident happened to you before? Yes _ No

To the best of your knowledge, has this accident occurred in your workplace before? Yes _ No

In general:

Is your job physically stressful? Yes _ No

Is your job mentally stressful? Yes _ No

Is your workplace noisy? Yes _ No

Have you changed jobs in the last year? Yes _ No

ABOUT YOU

Today's Date: ____/____/____ File #: _____

Name: _____

What You Prefer To Be Called: _____ _ Male _ Female

Birthdate: ____/____/____ Age: ____ S.S.#: _____

Home Address: _____

_____ CITY STATE ZIP

Home Phone #: _____

Other Phone #s: _____

Referred By: _____

Employer: _____ How Long? _____

Employer's Address: _____

_____ CITY STATE ZIP

Occupation: _____ Work Phone #: _____

Marital Status: _ Single _ Married _ Divorced _ Separated _ Widowed

Spouse's Name: _____



INSURANCE INFO

Co. Name: _____

Address: _____

Phone #: _____

Insured's S.S.#: _____

Group # (Plan, Local or Policy #): _____

Insured's Name: _____

Relation: _____ Date of Birth: ____/____/____

Insured's Employer: _____

Please inform front desk of 2nd Insurance source.

please continue on

