WORKMAN'S COMPENSATION QUESTIONNAIRE

Date: ________________________________

Name: ____ SSN: _________________________

Employer (at time of injury): ____

Address: ____ Suite #: ___________

City: ____________________________ State: ___________ Zip Code: ________________

Phone #: (_______)____________________

Insurance Company Name: ____

Address: ____

City: ___________________________ State: ___________ Zip Code: ________________

Date of Accident: ______________________Claim # ____

Adjuster's Name: __________________________ Phone #: (_______)_______________ Ext: ________

Precert Co: _______________ Phone: (_____)__________________ Fax: (_____)__________________

Where did the Accident Happen? ____

State Briefly the Cause of the Accident: ____

____

Have you worked any since the accident? (circle) Yes No

Have you received any prior treatment for this injury? (circle) Yes No

Physician's Name: ____

Are you currently under a Doctor's care for chronic illness? (circle) Yes No

Physician's Name: ____

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