WORKERS' COMPENSATION ONLINE INTERVIEW FORM

(Complete Form and Fax to 973-802-1055)

NAME: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____ COUNTY: _____

HOME PHONE: _____ CELL PHONE: _____

SSN: _____ SEX: MALE ☐ FEMALE ☐ DOB: _____

OCCUPATION: _____ MARITAL STATUS: _____

NAME/AGES OF CHILDREN: _____

_____

_____

NAME OF SPOUSE: _____ AGE: _____

EMPLOYER: _____

ADDRESS: _____ PHONE: _____

CITY: _____ STATE: _____ ZIP: _____ COUNTY: _____

WAGES: PER HOUR: _____ WEEKLY WAGE: _____

DATE OF ACCIDENT (LAST EXPOSURE): _____

BODY PART (S) INJURED: _____

INJURY: _____

LOCATION OF ACCIDENT: _____

HOW DID ACCIDENT OCCUR: _____

_____

DATE REPORTED: _____ TO WHOM: _____ POSITION: _____

WITNESSES: _____

DATE STOPPED WORK: _____ DATE RETURNED TO WORK: _____

TEMPORARY DISABILITY BENEFITS PAID: YES ☐ NO ☐ BY INS CO _____ STATE TDB _____

TDB PAID: FROM: _____ TO: _____

LENGTH OF EMPLOYMENT: _____ DATE STARTED: _____

NAMES/ADDRESSES OF DOCTORS/HOSPITALS

1. _____

_____

_____

TREATMENT FROM: _____ TO: _____

WAS TREATMENT AUTHORIZED? YES (◯) NO (◯)

2. _____

_____

_____

TREATMENT FROM: _____ TO: _____

WAS TREATMENT AUTHORIZED? YES (◯) NO (◯)

3._____

_____

_____

TREATMENT FROM: _____ TO: _____

WAS TREATMENT AUTHORIZED? YES ( ) NO ( )

4._____

_____

_____

TREATMENT FROM:_____ TO: _____

WAS TREATMENT AUTHORIZED? YES ( ) NO ( )

PRIOR ACCIDENTS AND/OR PAST HISTORY: _____

_____

_____

LANGUAGE: _____ INTERPRETER NEEDED: YES ( ) NO ( )

WORKERS' COMPENSATION INSURANCE COMPANY:_____

CLAIM NO: _____ ADJUSTER: _____

WHAT IS THE BEST TIME TO CALL: _____

TELEPHONE # _____

COMMENTS:

_____

_____

_____

_____

_____

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_____