**WORK RELATED ACCIDENT**

Date and time of Accident:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Was your injury directly related to your work? \_\_ Yes \_\_ No

Briefly describe the events that occurred just before and during your accident? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Give the address where the accident occurred: (If other than the employer’s address) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Was anyone else present during your accident? \_\_\_ Yes \_\_\_ No. Did you report your accident? \_\_\_ Yes \_\_\_ No

What recommendations did your employer make just after the 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

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

**WORK INSURANCE INFORMATION**

Co. Name & Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group # (Plan, Local, or Policy) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relation to Insured \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insured’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insured’s Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Insured’s Employer Name & Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**AFTER INJURY**

Did the accident render you unconscious?\_\_\_ Yes \_\_\_ No. If yes, for how long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please describe how you felt immediately after the accident: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you gone to a Hospital or seen any other Doctor? \_\_\_ Yes \_\_\_ No

When did you go? \_\_\_ just after the accident \_\_\_ the next day \_\_\_ 2 days plus

How did you get there? \_\_\_\_ Ambulance \_\_\_\_ Private transportation

Name of Hospital and/or Attending Physician: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Describe any treatment you received: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Were X-rays taken? \_\_\_ Yes \_\_\_ No , Was medication prescribed? \_\_\_ Yes \_\_\_ No

Have you been able to work since this injury? \_\_\_ Yes \_\_\_ No, Is your work restricted as a result of this injury?\_\_\_\_

Indicate **X** the symptoms that are a result of this accident? \_\_ Dizziness \_\_ Difficulty sleeping \_\_ Jaw problems

\_\_ Nausea \_\_ Memory loss \_\_ Irritability \_\_ Arm/shoulder pain \_\_ Back pain \_\_ Back stiffness \_\_ Headaches

\_\_ Fatigue \_\_ Numb hand/fingers \_\_ Lower back pain \_\_ Blurred vision \_\_ Tension \_\_ Chest pain

\_\_ Neck pain \_\_ Neck stiffness\_\_ Buzzing in ear \_\_ Shortness of breath \_\_ Leg pain \_\_ Ears ringing

\_\_ Stomach upset \_\_ Numb feet/toes \_\_ Other? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Is your condition getting worse? \_\_ Yes \_\_ No

Indicate your degree of comfort while performing the following activities:

 Comfortable / Uncomfortable / Painful Comfortable / Uncomfortable / Painful

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Lying on back |  |  |  | Sports |  |  |  |
| Lying on side |  |  |  | Working |  |  |  |
| Lying on stomach |  |  |  | Lifting |  |  |  |
| Sitting |  |  |  | Bending |  |  |  |
| Standing |  |  |  | Kneeling |  |  |  |
| Stretching |  |  |  | Pulling |  |  |  |
| Running |  |  |  | Reaching |  |  |  |

**RECOVERY**

To evaluate the effect that continuing work will have on your recovery please complete the following:

How many hours are in your normal workday? \_\_\_\_\_\_\_\_\_

Please indicate **X** your daily job duties and any activities which you are occasionally asked to perform:

\_\_ Standing \_\_ Driving \_\_ Operating equipment \_\_ Sitting \_\_ Twisting \_\_ Walking \_\_ Crawling \_\_ Typing

\_\_ Lifting\_\_ Working with arms above your head \_\_ Bending \_\_ Stooping \_\_ Other? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are there positions can you work in with minimum physical effort and for how long? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Prior to injury were you capable of working on an equal basis with others your age? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you work with others who can help you with any heavy lifting? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

While in recovery, is there any light duty work you could request? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ADDITIONAL INSURANCE INFORMATION**

Type of insurance: \_\_\_\_\_\_\_\_\_\_ Co Name & Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone # \_\_\_\_\_\_\_\_\_\_\_ Insured’s Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Relationship: \_\_\_\_\_\_\_\_ Policy #\_\_\_\_\_\_\_\_\_

Claim # \_\_\_\_\_\_\_\_\_\_\_\_Insured’s SS# \_\_\_\_\_\_\_\_\_\_\_\_\_ D.O.B.: \_\_\_\_\_\_\_\_\_\_\_\_ Insured’s Employer \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please remember you are ultimately responsible for your account.**

Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_