EMPLOYEE'S STATEMENT OF INJURY

Legal Name:_____ Address: _____

City:_____ State: _____ ZipCode: _____ Telephone_____

DOB: _____ Social Security #: _____ Marital Status: ___ S ___ M ___ D ___ W

Employer's Name: _____ Occupation: _____

Are you or your spouse a Medicare Beneficiary or have you applied for Social Security Disability? :_____

If so, date of Eligibility/Application: _____ Medicare Claim# _____

******* YOU ARE NOW REQUIRED BY LAW TO PROVIDE THIS INFORMATION TO US ********

Date of Injury: _____ Time of Injury: _____How Long Worked for Employer? _____

To Whom Did You Report This Injury? _____

Describe Fully What You Were Doing & How The Injury Occurred: _____

_____

_____

Nature & Location of Injury (Describe fully, give part of body, right/left, etc)_____

_____

Do You Have Other Employment? Yes _____ No_____ If "Yes", give name & address of company

_____

Name of Doctor: _____ Name of Witnesses: _____

Have you ever collected Workers' Compensation for a Work Injury? _____ Yes _____ No

If "Yes", give details (from whom, etc) _____

Have you claimed or received settlement for this injury before? _____Yes _____ No

If "Yes", from whom: _____

Have you ever had any other medical condition or injury involving this part of your body? _____ Yes _____No

If "Yes", give details & dates: _____

Remarks & Comments: (Use reverse side if needed) _____

_____

_____

I have read the above questions and answered each to the best of my ability. My responses are true and correct to the best of my knowledge. I have retained a copy (yellow) of this statement for my records.

_____ _____ _____

(Signature of Employee) (Witness Signature) (Date of Report)

Claim Strategies

Claims Management by Design

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