STATEMENT OF THE INJURED

NAME: ________________________________ MARRIED/SINGLE__________

ADDRESS______________________________TELEPHONE_______________

SOCIAL________________DATE OF BIRTH______________M/FM_________

HEIGHT/WEIGHT____________RIGHT/LEFT HANDED_________

DEPENDENTS (NAME/AGE)____

EMPLOYER__________________OCCUPATION_________________________

DATE OF HIRE_______________

DATE OF ACCIDENT_____________PLACE OF ACCIDENT________________

TIME OF ACCIDENT:__________am/pm

DESCRIBE THE ACCIDENT IN DETAIL, WHAT YOU WERE DOING, WHAT HAPPENED:

DESCRIBE YOUR INJURY:____

NAME/ADDRESSES OF WITNESSES/PERSONS HAVING KNOWLEDGE: ______

NAME OF PHYSICIAN ARE/HAVE SEEN:_______________________________

HIS ADDRESS/PHONE:____

DATE OF FIRST VISIT:____

FOLLOW UP TREATMENT____

DIAGNOSIS____

EXCUSED FROM WORK/ HOW MANY DAYS_______________________

MODIFIED WORK GIVEN/ WHAT RESTRICTIONS____________________

HISTORY:

ANY PREVIOUS ACCIDENTS OR INJURIES (work or otherwise) PLEASE GIVE DETAILS____

DO YOU HAVE ANY SERIOUS ILLNESSES, PLEASE EXPLAIN____________

____

PERSONAL PHYSICIAN'S NAME, ADDRESS, PHONE:__________________

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______________________________ ____________________

INJURED EMPLOYEE DATE