FAILURE TO COMPLETE THIS FORM IN ITS ENTIRETY
WILL DELAY PAYMENT FROM THE WORKERS' COMPENSATION BOARD

WCB Case Number (if you know it)____________________

1. **YOUR INFORMATION (EMPLOYEE)**

NAME:____ DATE OF BIRTH______________

MAILING ADDRESS:____

CITY:____STATE:_______ZIP:__________

SOC. SEC.#__________________ PHONE# (   )________________ GENDER: _______

2. YOUR EMPLOYER

EMPLOYER WHEN INJURED_________________________ PHONE# (   ) ______________

YOUR WORK ADDRESS____

EMPLOYER INSURANCE CARRIER: (THIS IS NOT YOUR HEALTH INSURANCE CO.)

____

ADDRESS:____

PHONE # (   )__________________CARRIER CLM.#______________________________

CLAIMS ADJUSTER:____________________________________ EXT#_______________

3. **YOUR JOB ON THE DATE OF THE INJURY:**

WHAT TYPES OF ACTIVITIES DID YOU NORMALLY PERFORM AT WORK?

____

____

3. **YOUR INJURY OR ILLNESS:**

DATE OF INJURY: ______________________

WHERE DID THE INJURY HAPPEN? ____

WHAT WERE YOU DOING WHEN YOU WERE INJURED?______________________________

____

HOW DID THE INJURY HAPPEN? e.g. (unloading a truck, typing a report, fell)

____

EXPLAIN FULLY THE NATURE OF YOUR INJURY: list body parts (e.g. twisted left ankle)

____

YOUR NAME_______________________________________ DATE. OF INJURY__________

WAS AN OBJECT (e.g. forklift, hammer) INVOLVED IN THE INJURY? YES_____ NO_____

IF YES, WHAT?____

WAS THE INJURY THE RESULT OF THE USE OR OPERATON OF A LICENSED MOTOR VEHICLE WHILE WORKING: YES__________ NO__________

HAVE YOU GIVEN YOUR EMPLOYER (OR SUPERVISOR) NOTICE OF INJURY?

YES____________ NO______________, IF YES, NOTICE WAS GIVEN TO______________

ORALLY_________ IN WRITING__________ DATE NOTICE GIVEN____________________

RETURN TO WORK:

DID YOU STOP WORK BECAUSE OF YOUR INJURY? YES_________ NO__________

IF YES, ON WHAT DATE:_____________________________

HAVE YOU RETURNED TO WORK? YES__________ NO______________

REGULAR DUTY____________ LIMITED DUTY____________

4. **MEDICAL TREATMENT FOR THIS INJURY:**

WHAT WAS THE DATE OF YOUR FIRST TREATMENT? _________________NONE________

WHERE WERE YOU TREATED? ER______, DOCTOR'S OFFICE________, CLINIC_________

HOSPITAL URGENT CARE________, HOSPITAL STAY OVER 24 HOURS____________________

NAME AND ADDRESS WHERE YOU WERE TREATED:_______________________________

____

IN THE EVENT I FAIL TO PROSECUTE THE CLAIM FOR WORKERS COMPENSATION FOR THIS ILLNESS OR CONDITION, OR IT IS DETERMINED BY THE WORKERS COMPENSATION BOARD THAT THE INJURY IS NOT THE RESULT OF A COMPASSABLE WORKERS COMPENSATION CASE,
I,____,
HEREBY AGREE TO PAY DR.______________________________ OF WINTHROP ORTHOPAEDIC ASSOCIATES HIS USUAL AND CUSTOMARY FEES FOR SERVICES RENDERED.

CLAIMANT SIGNATURE:________________________________**DATED:**______________

IF SIGNED BY OTHER THAN CLAIMANT, PRINT NAME, ADDRESS AND RELATIONSHIP

NAME: ____

ADDRESS: ____________________________________, **RELATIONSHIP:**________________