MIDLAND ORTHOPEDIC ASSOCIATES

WORKERS COMPENSATION

If this problem is related to a work injury, please complete the following questions. This is a legal document that will help determine your claim, so please be very accurate.

Patient Name: _____

Work related? _____ Date of Accident/Onset: _____

Who is your employer: _____

Address and phone number: _____

_____

Job title on date of injury: _____

What are your usual work activities? _____

_____

_____

Which part(s) of your body was injured (include side): _____

Prior to this accident, did you have a problem/pain in the affected area? ☐ YES ☐ NO

Did you sustain other injuries due to this accident? ☐ YES ☐ NO

If yes, please give details: _____

_____

Did you have immediate pain of the affected area at the time of the accident or a few days latter?

_____

Where (address with state) and How did the injury occur?

_____

Did you report the incident to your supervisor? ☐ YES ☐ NO When? _____

Who is the contact person or nurse specialist managing (name and phone number) your claim?

_____

Claim Number: _____

Did the company doctor see you for this claim? ☐ YES ☐ NO If so, when? _____

Have you been treated by another health care provider for this injury? If so, give details:

_____

_____

Are you currently working? ☐ YES ☐ NO **If yes, list your regular or modified duties:**

_____

_____

Are you on light duty? ☐ YES ☐ NO Is it available? ☐ YES ☐ NO

What are your restrictions? _____

_____

If you are NOT working, what is the date that you first missed work due to this injury? _____

How long have you been off from work in total due to this injury? _____

Are you being counseled by a lawyer for this injury? ☐ YES ☐ NO

DESCRIBE WHY THIS IS WORK-RELATED: (*In your own words and be precise)*

_____

_____

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Patient's Signature: _____ Date: _____