

# Workers' Compensation Fact Sheet

• **Place of Employment:** \_\_\_\_\_

**Address of Employer:** \_\_\_\_\_

**Phone # of Employer:** \_\_\_\_\_

• **Job Description:** \_\_\_\_\_

• **Date Injured** \_\_\_\_\_ **Time** \_\_\_\_\_ **AM / PM**

• **Address where injury occurred (if different from address of employer):**

• **Accident reported to employer?**     **Yes**                       **No**

**If yes, to whom did you report?** \_\_\_\_\_

• **In your own words, please describe the incident:**

• **Have you missed any time from work as a result of this injury?**     **Yes**                       **No**

• **Have you been seen by any other doctors for this injury?**             **Yes**                       **No**

**If yes, please list:**

**Doctor's name and address -**

**Type of treatment -**

• **Are you:**             **improved**             **unchanged**             **getting worse**

• **Prior to this accident, have you had any complaints similar to what you now have?**             **Yes**                       **No**

**If yes, please describe:**

**Signed** \_\_\_\_\_ **Date** \_\_\_\_\_