SIMPLOY
Simplified employment.

WORKERS' COMPENSATION QUESTIONNAIRE

EMPLOYEE STATEMENT

Unless immediate medical attention is required, please have the employee complete this form upon reporting an accident. If immediate medical attention is required, complete after treatment has been rendered.

Name: _____ Social Security #: _____
First Middle Last

Home Address: _____

Home Telephone Number: _____ Mobile Phone Number: _____

Date of Birth: _____ Sex: _____ Marital Status: _____ # of Dependents under 18: _____

Employer: _____ Date of Hire: _____

Rate per _____ (Hour, Week, Bi-weekly, Year): _____ # Days Worked/Week: _____ Hrs/Day: _____

Nature of Work/Position: _____

Date of Incident: _____ Time of Incident: _____ am/pm Time Began Work/Shift on Day of Injury _____ am/pm

Address of where accident/incident occurred: _____

List Names, Phone Numbers & Addresses of Witnesses: _____

_____

_____

State in your own words how the incident happened, including specific activity engaged in, sequence of events, equipment / materials/chemicals when accident/injury/illness occurred: _____

_____

_____

Was accident due to a slip or fall? ___ Yes ___ No (If so, were you wearing shoes made by "Shoes for Crews"? _____)

Describe safety measures/equipment/precautions applicable to this situation: _____
Where such measures utilized? ____Yes _____ No If no, please explain why not: _____

What is the nature of your injury? (Be specific) _____

Did you stop work immediately? ___ Yes ___ No (If "No", give last date worked: _____)

Name of Person Notified: _____

Was any treatment provided at incident site? ____Yes _____ No If yes, describe: _____

_____

If your opinion, do you require additional treatment beyond first aid? ____Yes _____ No

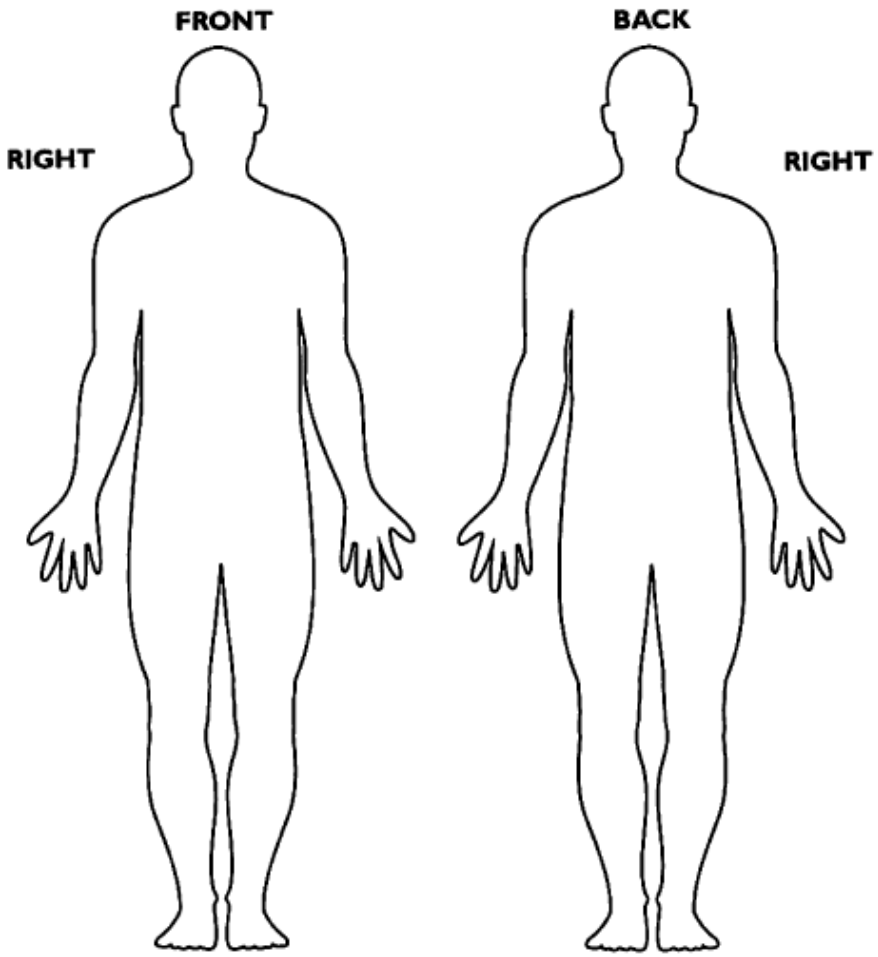
Have you had any previous injuries of this nature? ___ Yes ___ No (If "yes", please give full details: Date/Employer/Doctor/Etc.) _____

Authorization to Release Information: I hereby authorize any physician, hospital or other person or institution to permit the Insurance Company or its representative to examine, make or be furnished with any information concerning illness or injury sustained by me. This includes treatment, consultations, medical history, hospital records, prescriptions, diagnosis or findings. A photostatic copy of this authorization shall be considered as valid as the original. I understand that I must follow instructions provided by my physician, including work and personal restrictions.

Signature: _____ Date: _____

MARK THE AREAS OF THE BODY WHERE YOU FEEL THE DESCRIBED SENSATIONS WITH THE APPROPRIATE SYMBOLS FROM THE CHART BELOW.

NUMBNESS	+ + + + +	SHARP	/ / / / /
BURNING	x x x x x	DULL & ACHING	* * * * *
PINS & NEEDLES	0 0 0 0 0	WEAKNESS	▽ ▽ ▽ ▽ ▽



Indicate Pain Level Below

NONE SLIGHT MODERATE SEVERE UNBEARABLE

REFUSAL OF MEDICAL TREATMENT

I am declining my employer's offer of authorized medical treatment to cure and relieve the effects of the injury I am claiming to have sustained at work on _____(insert date). I understand that by declining my employer's offer of medical care, any treatment I obtain on my own will be at my own expense.

Employee Signature: _____ Date: _____