CLAIM FOR WORKERS' COMPENSATION
FACT SHEET

FACTS REGARDING CLAIMANT

*__ALL__ questions **MUST** be answered to the best of your ability. **If this form is not complete your appointment may be subject to being rescheduled.**

Date _____

1. Name: _____

2. Street Address or P.O. Box: _____

City: _____ State: _____ Zip code: _____

3. Telephone Number: Home: (_____)_____

Work: (_____)_____

Cell: (_____)_____

E-mail address: _____

4. Date of birth: _____

5. Age: _____

6. Social Security Number: _____ - _____ - _____

7. Marital status: _____

8. Name of spouse: _____ Age: _____

9. Names and ages of minor children:

_____

_____

10. Occupation: _____

Due to Section 111 Mandatory Medicare/Medicaid Reporting Requirements:

Are you a Medicaid recipient? YES NO

Are you a Medicare recipient (or will be within the next 30 months)? YES NO

If so, please provide your Medicare/Medicaid number: _____

* Please list an emergency contact:

Name: _____ Relationship _____

Address: _____

Phone: _____

11. How were you referred to our office?

Turner Law Offices Website □ Internet □ Injury Helpline □

Phone book, which one? Yellowbook □ Superpages □

Attorney □ Name _____ Family Member/Friend □ Name _____

Other □ _____

12. Name and complete address of present employer: _____

_____

13. Are you right or left handed? _____

FACTS REGARDING ACCIDENT

14. Name and complete address of employer at time of accident: _____

_____

15. Date of accident: _____

16. Time of accident: _____

17. Place of accident: _____

18. Description of the job you were performing at time of accident: _____

_____

_____

_____

19. Description of the accident: _____

_____

_____

20. Names and addresses of witnesses to accident: _____

21. Name and address of your supervisor at time of accident: _____

_____

_____

22. Name, job title and address of the person to whom you reported the accident: _____

_____

23. Date and time you reported the accident: _____

24. Was the accident reported orally, written or both? _____

25. At the time of the report, did you receive a copy of the Illinois Industrial Commission Workers' Compensation handbook? _____

26. Description of what you reported: _____

_____

_____

_____

27. What were your gross weekly earnings at time of accident? _____

28. Were you required to work overtime? _____ how often? _____

29. Description of your injuries: _____

_____

_____

30. For what period of time were you off work? (Give dates): _____

_____

31. When were you released to return to work? _____

32. If you were released to return to work, who released you? _____

_____

33. What was your rate of compensation while you were off work? $_____

34. How long did you receive such compensation? _____

35. What was the name of the insurance company from which you received the compensation? _____

_____

36. Have you received a prior settlement offer for this injury from the worker's compensation insurance company? Yes / No. If so, please provide the details of the offer, or if a written offer, please provide a copy of the offer.

MEDICAL HISTORY - (Please complete the attached Health Care Provider Information Sheet)

37. Are you still being treated? _____

38. If so, state the treatment being received: _____

_____

39. Will you require future treatment? _____

40. If so, describe treatment requirement: _____

41. Describe present physical complaints: _____

_____

_____

42. Have you been injured before? _____

43. If so, state when you were injured, the nature of the injury, the treatment of said injury, and any problems you still have as a result of said injury: _____

_____

_____

_____

44. Have you filed a claim(s) in the Illinois Workers' Compensation Commission prior to this time? If yes, please explain: _____

_____

Health Care Provider Information Sheet

*** ATTENTION ***

It is the client's responsibility to keep TURNER & SACKETT updated throughout the pendency of the case of any and all medical treatment and related medical bills associated with his/her claim. Any unknown medical bill(s)/liens/subrogations or any medical bill(s)/liens/subrogations provided after the conclusion of the case *WILL BE THE RESPONSIBILITY OF THE CLIENT.*

For Office Use Only:
DOA: _____
Injured Party: _____

Group Health Insurance Carrier: _____
Policy Number: _____
Insured: _____
Primary Care Provider's Name, Address and Phone Number_____
_____

Please complete the information listed below for all physicians, hospitals, chiropractors, dentists, and oral surgeons, or any other medical provider who has treated you due to this accident.

Name of Provider/Facility: _____
Treating Physician: _____
Complete Address: _____
Phone Number: _____
Dates Treated: _____
Description of Treatment: _____
Bills Paid: Yes: _____ No: _____ Unknown: _____

Name of Provider/Facility: _____
Treating Physician: _____
Complete Address: _____
Phone Number: _____
Dates Treated: _____
Description of Treatment: _____
Bills Paid: Yes: _____ No: _____ Unknown: _____

Name of Provider/Facility: ____
Treating Physician: ____
Complete Address: ____
Phone Number: ____
Dates Treated: ____
Description of Treatment: ____
Bills Paid: Yes: ____________________ No: _____________________ Unknown: _____________________

Name of Provider/Facility: ____
Treating Physician: ____
Complete Address: ____
Phone Number: ____
Dates Treated: ____
Description of Treatment: ____
Bills Paid: Yes: ____________________ No: _____________________ Unknown: _____________________

Name of Provider/Facility: ____
Treating Physician: ____
Complete Address: ____
Phone Number: ____
Dates Treated: ____
Description of Treatment: ____
Bills Paid: Yes: ____________________ No: _____________________ Unknown: _____________________

Name of Provider/Facility: ____
Treating Physician: ____
Complete Address: ____
Phone Number: ____
Dates Treated: ____
Description of Treatment: ____
Bills Paid: Yes: ____________________ No: _____________________ Unknown: _____________________

Name of Provider/Facility: ____
Treating Physician: ____
Complete Address: ____
Phone Number: ____
Dates Treated: ____
Description of Treatment: ____
Bills Paid: Yes: ____________________ No: _____________________ Unknown: _____________________