WORKERS' COMPENSATION HISTORY

Name:	Age:	DOB		Male	Female
Name:Address S.S.# Employer's Name Address Have you retained legal counsel for	City		State	Zip	
S.S.#	Driver's License #				
Employer's Name		Teler	ohone		_
Address	City		_ State _	Zi	p
Have you retained legal counsel for	this injury? Yes	No			
If marked Yes, Provide Attorney Na	ume, Address & Phone N	umber:			
INJURY DESCRIPTION					
Date present injury was received	Time of	injury			AM/PM
Overtime Yes	No				
Witness to the accident? Name		Title			
Who reported accident? Name		Title			
What medical attention was rendere	d?				
Whom by? Nurse M.D	D.O. D.C.	Other emp	oloyee	Other	
How did this injury occur?					
Chief Complaint					
SymptomsSince the injury, are your symptoms					
Cinco the initian and really commentance	improving the g		atting wa	rco	
Since the injury, are your symptoms	. improving uie sa		getting wo	150	
If working on a machine, give descr	iption				
If working on a machine, give descr Do you use foot or hand levers? Ye	iption s No Do yo	ou work ove	rhead? Ye	es No	0
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If working on a machine, give descr Do you use foot or hand levers? Ye Do you have to reach? Yes <u>N</u> Movements on the job: do you move From where to where?	iption Do yo os No Do yo lo If Yes, Where? e to your? Right Lef Do you le	ou work ove t Up eft from? Gr	rhead? Ye _ Down ound	es No Under Bench	Over Platform
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I certify that the above information is correct to the best of my knowledge.

Signed _____ Date _____