The Croft Law Office

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PERSONAL INFORMATION **Please read and sign the attached letter first.**		
Your Full Name	Date of Injury(s)	AWCB Case No(s).
Address _____ _____	**Home:** _____ **Cell #:** _____ **Email**: _____	
Date of Birth ____/____/_____	SSN _____	
Employer at Time of Injury(s)	Workers' Comp Insurance Company(s)	City of Injury(s)
Start date with Employer:_____ Last date worked with Employer: _____		
Job title:_____ Wage at time of injury:_____/ per month/day/hour		
Time Loss Benefits _____ **Yes** I am receiving compensation of $_____ per week _____ I last received compensation on _____ _____ **No** I have never received compensation.		
Controverted (denial of benefits) Date _____ Reason: _____ **YOU MUST SUBMIT A COPY OF THE CONTROVERSION NOTICE**	Completed report of injury? ____ Y ____ N Date _____ **YOU MUST SUBMIT A COPY OF THE REPORT OF INJURY**	
I ___ have ___ have not applied for reemployment benefits since my injury date If applied for reemployment when _____ Status of reemployment _____Approved on _____ _____ Denied on _____ **YOU MUST SUBMIT A COPY OF ALL ELIGIBILITY EVALUATIONS, REPORTS, LETTERS, ETC.**		

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MEDICAL

Who Is Your Treating Doctor(s)?
Name _____
Name _____
Name _____

Has the Employer sent you to a doctor?
YOU MUST SUBMIT A COPY
Name _____
Has your doctor seen the report?
_____Yes _____ No

Part of body injured:_____
What is the first date you sought treatment for this injury: _____

What is your permanent partial impairment rating? _____%
You must submit a copy of the doctor report.

Have you had surgery? _____ No _____ Yes (attach copy of surgery reports)

HAVE YOU

1. received **unemployment**
   ___yes, how much _____for what time period _____
   ___no
2. returned to **work**
   ___yes, earning _____for what time period _____
   ___no for whom _____
3. received **Social Security** disability or retirement
   ___yes, how much _____for what time period _____
   ___no
4. I _____was _____ was not a member of a **Union** at the time of my injury
   If yes Name of Union _____
   received **Union** disability benefits
   ___yes, how much _____for what time period _____
   _____no
5. **reinjured** yourself – at home, at work, or anywhere else
   ___yes, date _____ treatment _____
   where did the reinjury happen _____
   ___no
6. received notice of a **child support** lien
   ___yes, how much _____for what time period _____
   ___no
7. received **financial assistance** from the State – **Medicare or Medicaid**
   ___yes, how much _____for what time period _____
   ___no

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8. received a private or employer **disability** policy including PERS, TERS
From whom:_____
___yes, for what time period _____
___no

9. been **arrested** within the last five (5) years
___yes, please explain period _____
_____
___No

10. been involved in an **automobile accident** within the last ten (10) years
If yes - When _____
Where _____
Part of body injury _____
If yes - When _____
Where _____
Part of body injury _____

11. I ___ have _____ have not attempted to **return to work**.
I ___ am _____ am not working at this time.
If you are currently working is it for the same employer at the time of injury?
_____ Y _____ N

12. had a prior **workers' compensation injury**
If yes - When _____
Which State_____
Part of body injury_____
If yes - When _____
Which State_____
Part of body injury _____

13. had a settlement in any prior workers' compensation injury
_____ Y please submit a copy of the settlement agreement
_____ N

Please list all **Private Health Insurance** maintained by either you or your spouse at the time of injury.
Name of Ins. Company Whose coverage
_____ _____
Have they paid any of your medical bills?
_____ Yes
_____ No