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WORKERS' COMPENSATION INTAKE SHEET

IF ANY QUESTION DOES NOT APPLY TO YOU, WRITE "N/A" IN THE BLANK.

I. PERSONAL INFORMATION

Name: _____

Address: _____

Email address: _____

Work Phone: _____

Date of Birth: _____

Name of Spouse: _____

Spouse's Occupation: _____

Name and birth dates of dependents (including spouse): _____

Name, address and telephone number of close friend or relative who will always know your whereabouts or how to reach you:

How far did you go in school? _____

II. EMPLOYER INFORMATION

Company Name: _____

Address: _____

Phone: _____

Name and job title of your immediate supervisor: _____

When did you begin working with this company? _____

What was your job title at the time of your accident? _____

Describe your duties: _____

Are you a union member? _____

If yes, what is the name and phone number of your union representative?

List the name, address, phone number and employment dates of previous employers:

III. INSURANCE INFORMATION

WC Insurance Company: _____

Address: _____

Adjuster: _____ Phone: _____

Policy No.: _____ Claim No.: _____

IV. ACCIDENT INFORMATION

Date of accident: _____ Time of accident: _____

Location of accident (**including county**):

Describe how the accident happened (use back of page if necessary):

Was your accident caused in whole or in part by carelessness or negligence of persons other than your fellow employees? _____

Explain: _____

Was your accident caused in whole or in part by the use of any piece of defective machinery or equipment? _____

Explain: _____

NOTE: IF YOUR INJURY WAS CAUSED IN WHOLE OR IN PART BY DEFECTIVE MACHINERY OR EQUIPMENT, THERE EXISTS THE POSSIBILITY OF A CLAIM AGAINST THE MANUFACTURER, OR OTHER PERSON(S) RESPONSIBLE FOR ITS CONDITION.

V. WITNESSES TO YOUR ACCIDENT

Name: _____

Address/phone: _____

Employer: _____

Name: _____

Address/phone: _____

Employer: _____

Name: _____

Address/phone: _____

Employer: _____

VI. NOTICE

Did you give notice of your injury or condition to the company? _____

Name of person to whom you gave notice and date you gave notice:

Give details of how you gave notice, including time, place and witnesses:

If you did not personally give notice to the company, state who did. Give details:

VII. WAGE INFORMATION

Are your wages paid: Weekly \$ _____ Monthly \$ _____

Semi Monthly \$ _____ Hourly \$ _____

Rate of pay (before tax deductions) : \$ _____ per _____

Average hours worked per week: _____

If you received tips bonuses or commissions, how much did they average per week?

If you have not worked for the company for 13 weeks prior to the accident, what was the average weekly pay for other employees with your same job classification?

\$ _____ per _____

Did your employer provide you with meals, uniforms, housing, transportation, or other fringe benefits?

If so, describe and estimate the weekly value: _____

VIII. LOST TIME

When did you first lose time from your job due to your injury?

Are you still off the job due to your injuries? _____

If you returned to work for the same employer, state the period of time you were back at work and any decrease in your earnings:

If you are no longer working for the same employer, state the date you left and the reason for leaving?

If you are working for or have worked for another employer since your accident, state the period of time you were back at work, any decrease in your earnings, and the name, address and phone number of the employer: _____

If you have received any weekly Worker's Compensation checks for your injury, what was the weekly amount? _____

IX. INJURIES

State in detail all injuries received as a result of this accident:

List here any pre-existing or subsequent illnesses or accidents. This is particularly important if they have any relation to the problems caused by your job accident. ***Failure to mention these matters, no matter how trivial they may seem, could be harmful to your case.***

Upon applying for a job with this company, did you fill out an employment application and/or medical questionnaire? ____ Yes ____ No

Previous treatment to the injured areas? ____ Yes ____ No

Any limitations on your ability to perform your job? ____ Yes ____ No

If you answered yes to any of the above, did you indicate this on your application/medical questionnaire for your employer? If so, please explain:

If you did not reveal prior injuries, previous treatment, prior claims or limitations to your employer,
Please explain:

[Please note that failing to reveal a prior medical condition to your employer which is now involved in this injury may prevent you from pursuing your claim.]

X. MEDICAL TREATMENT

List the **names and complete addresses and/or telephone numbers** for all physicians who treated or evaluated your Worker's Compensation injuries and the months during which you received their treatment or evaluation:

List the names and addresses of all hospitals in which you were treated for your Worker's Compensation injuries (including emergency room treatment, diagnostic screenings, tests, etc.), and the months during which you received this treatment:

Did your employer have a list of four or more doctors, clinics or hospitals posted in a prominent place?

*****Important***** Explain how you came to be seen by each doctor listed above. For example:

1. Was he selected from the posted panel by you or your employer;
2. Suggested by you and agreed to by your employer or his insurance company;
3. Suggested by your employer or his insurance company and agreed to by you;
4. A referral from a prior doctor;
5. A referral from the doctor in the emergency room where you were taken;
6. A doctor to whom you were sent by your employer or his insurance company for an opinion or evaluation only; or
7. None of the above.

<u>Doctor</u>	<u>How you came to be seen by doctor</u>

Mileage from home/office to doctor: _____

Mileage from home/office to pharmacy: _____

XI. BACKGROUND

Have you ever applied for Worker's Compensation benefits before? _____

When? _____ Details: _____

List all prior accidents and injuries. This includes automobile accidents and any other kind of injury.

Give date, place, injury and how the claim was disposed of.

NOTE: IF YOU HAVE BEEN TREATED FOR ALCOHOLISM, DRUG ADDICTION, OR CONVICTED OF A VIOLATION OF ANY CRIMINAL STATUTE, PLEASE DISCUSS THIS WITH YOUR ATTORNEY. THIS INFORMATION IS IMPORTANT TO YOUR CASE AND WILL BE KEPT CONFIDENTIAL.

List any past lawsuits you have been involved in, giving the full details as to each case:

Have you ever had surgery? _____ Details: _____

Have you ever applied for Social Security benefits? _____

Details: _____

Have you ever applied for unemployment benefits? _____

When? _____

Miscellaneous or additional information you feel is important concerning your Workers' Compensation claim: _____

Please list any questions you have regarding your Workers' Compensation

claim: _____

How did you hear about us? _____