Workers Compensation Claim Intake Information

Name: Last, First Middle

M ◯ F ◯

Date of Birth | Social Security Number | Sex

e-mail address

Employer Name | Hire Date?

Yes ◯ No ◯

Home Phone | Work Phone

Employer Phone | Last Date Worked? | Still Working?

Address

Employer Address

City, ST ZIP Code

City, ST ZIP Code

Injury Information

Injured Body Part (s):

Injured Body Part (s): (second injury, if applicable)

Date of Injury | Reported to?

Date of Injury | Reported to?

Briefly describe how injury occurred:

List any Surgeries or current treatment:

While unrepresented, have you seen an AME, QME or Panel QME? Yes ◯ No ◯

Name of Doctor(s) you are treating with:

(If Yes; please give names):

Has your Doctor released you to return to work? No ◯ Yes ◯ Have you returned to work? No ◯ Yes ◯

Have you had any motor vehicle accidents or non-industrial injuries? Yes ◯ No ◯

If yes, list date, brief description, what body part was injured and where you received treatment:

Insurance Carrier Information

Insurance Carrier Name

Carrier Address | Phone Number

Claim Number | Adjuster Name

Other Information

Do you have any prior Work Comp injuries or claims? Yes ○ No ○ (If yes, please list below):

Name of any current or prior attorneys:

Have you applied for or receiving SDI; SSD; SSI or UEI?

Reason for seeking representation:

Other Comments:

Please fill in this form, print and FAX it to Wheeler & Beaton, A Professional Law Corporation, at

(805) 541-5434

Upon receipt, we will review the information and call you to set an appointment for a Free Consultation with one of our Attorneys. Please give us one working day to process before calling our office. Thank you for your cooperation.

Print

Clear Form