WORKERS COMPENSATION

We have agreed to treat you for a work compensation injury/ illness. Prior to treatment and or further treatment the following information is needed. Please note: ALL areas must be complete

Patient Name	Date of Accident
Name of Employer	
Contact Person's full name	Phone

Was this reported to your employer Yes No	Date reported with employer / /
How long have you been employed with your current employer:	
How many hours a day do you work:	
Please give a detailed explanation of the job you do with your current position. If it is due to repetitive work please explain in detail how your position is repetitive	
Give detailed explanation of how the injury occurred if it was due to an accident at work:	
What is your injury:	

*****Failure to comply will result in you, the patient, being responsible for payment in full.*****

I understand that I am required to get the form completed by my employer prior to my appointment and if I don't bring the form to my appointment, then my appointment will be rescheduled till the form is complete.

In addition, I agree I am responsible to notify this office immediately if there is a change in claim status or an Attorney is retained by me.

____ ____________________

Patient Signature Date

Employee to fill out

We have agreed to treat your employee for the injuries that they sustained at work. Prior to treatment and or further treatment the following information must be received.

Employee Name:	Date of Accident:

Please fill out the following information regarding the employee's position and fill out the physical requirements analysis.

Job title:	How long the employee has been employed:	
Length of scheduled shift	Hours the employee works per day:	
How many breaks are given:	Length of breaks:	
Workers Compensation carrier:		
Workers Compensation carrier's address:		
Workers Compensation carrier's telephone:		
Workers Compensation Carrier Claim Number:		
Name of contact person:	Phone number:	Fax number:
address where notes and bills are to be forward to:		

Please have the employee bring the requested information to their scheduled appointment or you may fax it to our office at (815) 223-7443. If the information is not received by the employee's appointment we will reschedule the appointment till the information is received.

Employer to fill out

PHYSICAL REQUIREMENTS ANALYSIS

Employer ______________________________ Job Title: ______________________________

Employee Name: ____

PHYSICAL ACTIVITY

Mark all responses using the following codes:

- N – Never
- O – Occasional represents 1-36% or 1-2 hours of an 8 hour work day.
- F – Frequently, represents 37-86% or 3- 6 hours of an 8 hour work day.
- C – Continuous represents 87-100% or 7-8 hours of an 8 hour work day.

Activity		N	O	F	C
Walking:		☐	☐	☐	☐
Sitting/Standing:		☐	☐	☐	☐
Reaching:	Shoulder Height	☐	☐	☐	☐
	Above Shoulder Height	☐	☐	☐	☐
	Below Shoulder Height	☐	☐	☐	☐
Climbing:		☐	☐	☐	☐
Pulling/Pushing:	Less than 25lbs.	☐	☐	☐	☐
	25 lbs. to 50 lbs.	☐	☐	☐	☐
	Over 50 lbs.	☐	☐	☐	☐
Lifting:	Less than 25 lbs.	☐	☐	☐	☐
	25 lbs. to 50 lbs.	☐	☐	☐	☐
	Over 50 lbs.	☐	☐	☐	☐
Carrying:	Less than 25 lbs.	☐	☐	☐	☐
	25 lbs to 50 lbs.	☐	☐	☐	☐
	Over 50 lbs.	☐	☐	☐	☐
Crawling/Kneeling		☐	☐	☐	☐
Bending/Stooping/Crouching		☐	☐	☐	☐
Twisting/Turning		☐	☐	☐	☐
Repetitive Movement		☐	☐	☐	☐

PHYSICAL EXPOSURE – Mark where applicable with "X".

Harmful Physical Agents:
- Heat/Cold ☐
- Noise ☐
- Ionizing/Non-ionizing Radiation ☐

Unprotected Heights: ☐
Hazardous Substances: ☐
Mechanical Hazards: ☐
Infectious Diseases: ☐

Lighting:
- Bright ☐
- Dim ☐

PHYSICAL ABILITY	ACCEPTABLE MINIMUM					
Vision	Good	☐	Poor	☐	Blind	☐
Color Vision	Normal	☐	Impaired	☐		
Hearing	Normal	☐	Moderate Loss	☐	Deaf	☐
Manual Dexterity	Good	☐	Fair	☐	Poor	☐

ADDITIONAL REQUIREMENTS:

Reviewed:
Revised:

Department Manager: ____ **Date:**_______________

Employer to fill out