SMITH WATTS & ASSOCIATES, LLC

Workers' Compensation

DATE:_____ DATE OF INJURY:_____

CLIENT:_____ EMPLOYER:_____

ADDRESS:_____ ADDRESS:_____

_____ _____

PHONE:_____ PHONE:_____

SSN:_____ INS. CARRIER:_____

DOB:_____ _____

DRIVER'S LICENSE #: _____ EMAIL: _____

DESCRIPTION OF INCIDENT:

_____

_____

_____

DESCRIPTION OF INJURIES:

_____

_____

_____

PERSON NOTIFIED (SUPERVISOR, ETC.)_____

DATE NOTIFIED_____

DATES OF MISSED WORK_____

WAGES: WEEKLY_____ COMP. RATE_____

MONTHLY_____

TEMPORARY TOTAL DISABILITY RECEIVED?_____

AMOUNT_____

DATES RECEIVED:_____

MEDICAL PROVIDERS:

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

PREVIOUS INJURIES, COMP. CLAIMS, OR DISABILITIES:

_____

_____