



NORTHWESTERN
HEALTH SCIENCES
UNIVERSITY

WORK INJURY INFORMATION

Name _____ Date _____

WORK ACCIDENT INFORMATION:

Date of injury _____

Was this injury reported to your employer? Yes / No Date reported to employer _____

Employer's name _____ Phone _____

Employer's address _____

Describe the accident _____

OTHER DOCTORS SEEN FOR THIS CONDITION:

Doctor's name _____ Phone _____

Address _____

Did you miss any time from work? Yes / No. If yes, how much? _____

Have you returned to the same job? Yes / No. If not, why? _____

Are you represented by an attorney? Yes / No

Attorney's name _____ Phone _____

Address _____

Insurance company _____ Claim number _____

Address _____

Adjuster _____

Adjuster's phone # _____