



WORKERS' COMPENSATION CLAIM

INITIAL INDUSTRIAL VISIT QUESTIONNAIRE AND EMPLOYER'S INDUSTRIAL TREATMENT NOTICE

IMPRINT AREA

UPON COMPLETION: FOLD AT LINES AND INSERT IN A #10 WINDOW ENVELOPE

TO: _____
ATTENTION: PERSONNEL DEPARTMENT

← EMPLOYER'S NAME
← EMPLOYER'S ADDRESS
← EMPLOYER'S CITY/STATE/ZIP CODE

TYPE OF BUSINESS	WORK/EMPLOYER'S PHONE ()
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FOLD HERE

PATIENT'S NAME		SEX <input type="checkbox"/> M <input type="checkbox"/> F	BIRTH DATE	SOCIAL SECURITY NO.
PATIENT'S ADDRESS		CITY	ZIP CODE	HOME PHONE ()
OCCUPATION (TYPE OF WORK YOU DO) ARE YOU A LONGSHOREMAN? <input type="checkbox"/> Yes <input type="checkbox"/> No				
LOCATION (ADDRESS) WHERE YOU WERE WORKING WHEN INJURED				
DATE YOU WERE INJURED OR BECAME ILL		TIME <input type="checkbox"/> AM <input type="checkbox"/> PM	LAST DAY WORKED	
HAVE YOU REPORTED THIS AT WORK? <input type="checkbox"/> YES <input type="checkbox"/> NO		For injuries/conditions on or after 01-01-90, all injured workers must complete the Employee's Claim For Workers' Compensation Benefits (Form DWC-1). Have you completed and returned the form to your employer? <input type="checkbox"/> Yes <input type="checkbox"/> No		

DATE OF FIRST VISIT TO THIS KAISER FACILITY FOR THIS INJURY	NAME OF PHYSICIAN
HAVE YOU BEEN SEEN AT OTHER KAISER FACILITIES FOR THIS INJURY? PLEASE LIST	

Any person who makes or causes to be made any knowingly false or fraudulent material statement or material representation for the purpose of obtaining or denying workers' compensation benefits or payments is guilty of a felony.

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PLEASE EXPLAIN IN DETAIL WHAT HAPPENED TO YOU AT WORK THAT CAUSED YOU TO BECOME ILL OR INJURED. HOW DID IT HAPPEN? WHEN DID IT HAPPEN? WHAT PART OF YOU DID YOU HURT?

DEAR EMPLOYER: PLEASE BE ADVISED I HAVE SELECTED THIS FACILITY FOR THE PURPOSE OF PROVIDING MEDICAL TREATMENT TO CURE OR RELIEVE THE EFFECTS OF THE INJURY DESCRIBED ABOVE.

YOUR SIGNATURE

TODAY'S DATE