

THE LAW OFFICES OF NATHANIEL F. HANSFORD
WORKERS' COMPENSATION - CLIENT INFORMATION

CLIENT'S BASIC INFORMATION

Client's Full Legal Name: _____
Client Address: _____ Apartment No. _____
City: _____ State: _____ Zip Code: _____
County of Residence: _____ Time at this address: _____
Home Phone: _____ Cell Phone: _____
Work Phone: _____ Other: _____
Email Address: _____ May we use email to contact Client? Y / N
Sex (circle one): Male / Female SS# / Tax ID#: _____
Birth date (mm/dd/yyyy): ____ / ____ / ____

EMPLOYER INFORMATION

Name of Direct Employer: _____
Employer Address: _____
City: _____ State: _____ Zip Code: _____
County of Employer : _____ Name of Direct Supervisor: _____
Phone: _____ Alternate Phone: _____
Cell Phone: _____ Facsimile: _____

WORKERS' COMPENSATION INSURANCE INFORMATION

Name of Insurer: _____
Insurer Address: _____
City: _____ State: _____ Zip Code: _____
Name of Adjustor: _____ Adjustor E-mail: _____
Phone: _____ Alternate Phone: _____
Cell Phone: _____ Facsimile: _____
Claim Number: _____
Statement Given to Insurance? (circle one) Yes / No If Yes, Explain: _____

Has the Employer been notified of the accident/injury? (circle one) Yes / No

If so, when and how was notice given? _____

To whom was notice given? _____ His/Her Title: _____

Did anyone witness that the Employer was notified? (circle one) Yes / No / Unknown

If so, who are those witnesses? _____

If Claimant did not give notice personally, who gave notice to the company? _____

ACCIDENT & INJURY INFORMATION

Date of Injury: _____ Day of Week: _____ Time of Day: _____

County of Injury: _____ City: _____ State: _____

Describe in detail how the accident occurred: _____

Describe in detail *ALL* injuries suffered in the accident: _____

INCOME INFORMATION

Gross *Rate of Pay* before Taxes: \$ _____ paid to client per _____

Average Weekly Wage: \$ _____ Client paid in: (circle one) cash / check

Hours worked per Week: _____ Days worked per Week: _____

How long has Client been making this amount? _____

How long has Client worked with the employer? _____

When after the injury did Client first miss work? _____

Has Client returned to work since the injury? (circle one) Yes / No

If Client has returned to work since the injury, when did he return and in what capacity? _____

After returning to work, did Client's pay change? (circle one) Yes / No

How much is Client making now? _____

MEDICAL TREATMENT

1st Doctor/Medical Facility: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Facsimile: _____

2nd Doctor/Medical Facility: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Facsimile: _____

PLEASE ATTACH ANY MEDICAL RECORDS, CHECK STUBS, LETTERS RECEIVED FROM EMPLOYER OR INSURANCE.