INSPIRING WELLNESS - WORKERS COMPENSATION DETAILS

WORKER:

ADDRESS:

DATE OF BIRTH

EMPLOYER:

EMPLOYER'S CASE MANAGER

EMPLOYER PHONE NO:

EMPLOYERS EMAIL ADDRESS:

INSURANCE COMPANY:

ADDRESS:

PHONE NO:

FAX NO.:

CASE MANAGER NAME:

EMAIL ADDRESS:

DATE OF INJURY:

CLAIM NO.:

DOCTOR:

ADDRESS:

PHONE NO.:

WHAT IS YOUR INJURY:

WHAT HAPPENED:

WHAT ARE YOUR NORMAL DUTIES:

WHAT ARE YOUR CURRENT DUTIES (and what you cannot do yet):

IMPACT ON ACTIVITIES OF DAILY LIVING (EG SLEEP, PAIN, DEPRESSION, RANGE OF MOTION, WEAKNESS)

OMPQ SCORE