

WORK/COMP QUESTIONNAIRE

Name _____ Approved by _____ (Office Use Only)

1) Date of Accident ____ / ____ / ____ 2) Time of Accident ____ : ____ (AM / PM)

3) Name of Employer at time of Accident _____

4) Employer Address _____

5) City _____ State _____ Zip _____ Phone # () _____

6) Occupation _____

7) In terms of an 8 hour workday I: (Circle number of hours for each activity)

Sit — (1 2 3 4 5 6 7 8) hours

Stand — (1 2 3 4 5 6 7 8) hours

Walk — (1 2 3 4 5 6 7 8) hours

8) On the job, I perform the following activities: (Circle as many as apply)

A) Bend/Stoop B) Squat C) Crawl D) Climb E) Reach above shoulders F) Crouch G) Kneel H) Push/Pull I) Maintain awkward posture

9) On the job, I regularly lift between:

A) 1-10 lbs. B) 11-24 lbs. C) 25-34 lbs. D) 35-50 lbs. E) 51-74 lbs. F) 75-100 lbs.

10) Are you required to bend over while lifting? (Y/N)

11) Do you use your hands for repetitive movements such as: (Circle as many as apply)

A) Simple Grasping (left hand) B) Firm Grasping (left hand) C) Fine Manipulating (left hand)
D) Simple Grasping (right hand) E) Firm Grasping (right hand) F) Fine Manipulating (right hand)

Prior to this accident were you experiencing any similar physical complaints? (Y/N) If "YES" please explain: _____

In your own words, please describe accident: _____

Important: This form may be used in the determination of your Workers Compensation eligibility and the amount of compensation you are entitled to. To protect your rights please fill out this form correctly and completely!