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WORKERS' COMPENSATION MATTER

DATE	:				
1.	Name:				
	Address:				
	City: State:	Zip Code:	_ Country:		
Phone:	(Home) ()				
Email:					
	ong at present address?				
2.	S.S.#:				
	Date of Birth:	<u> </u>			
3.	Single: Divorced	: Separated:	Widowed		
4.	Spouse's Name (if applicable):				
5.	Number of children or other dependents: Children: Dependents:				
6.	Occupation:				

7.	Name, address, phone number of employer:					
	Name:					
	Address:					
	City:	State:	Zip Code:	Country:		
	Phone:					
	(Business) ((Fax) ()	<u>-</u>			
Date	s of Employment:					
Emp	loyer's Insurance Ca	rrier:				
Are y	you paid hourly or by	/ salary?				
Wha	t are your wages and	pay period?				
8.	Date of Accident:					
9.	Where accident of	ccurred:				
10.	How did accident	occur?:				
11.	Did you miss any	time from work? Ye	s No			
	If yes, provide dat	es:				
12.	Did you report yo	ur injury to employer?	Yes No _			
If yes	s, whom did you rep	ort the accident to?				
Nam	٠.					
Title	:					
Whe	n did you report the	accident?				

13.	Have you received Temporary Disability?:	Yes	No
If yes,	how much temporary disability have you received?		
14.	Have you received Social Security Disability?	Yes	No
If yes,	how much Social Security Disability have you recei	ived?	
15.	Was Medical Aid furnished by your Employer?	Yes	No
16.	How much do you regularly earn per week?		
	Is that based on an hourly wage? Yes	No	
17.	How did the injury occur?		
18.	Describe extent and character of injury:		
19. injurie a.	Give names and addresses of treating physicians ares:	-	h respect to your
υ			
c			
d			

e	
f	
g	
h	
/ / to / [present]	
List prior employment:	
21. Prior Worker's Compensation Claims (include description of each claim, date of claim	າ):
22. Other attorneys currently or previously involved:	
23. List all other facts you feel are relevant.	
	