WORKERS' COMPENSATION CASE INTAKE FORM

Date _____

CLIENT INFORMATION

Client _____ Address _____

Phone (H) _____ (W) _____ _____

Cell _____ Date Retainer Agreement Signed _____

SSN _____ E-Mail _____

Date of Birth _____ Driver's License _____

Education _____

Spouse/Partner's Name _____ Spouse/Partner Phone _____

Dependents _____ Referred By _____

Emergency Contacts (Name/Address/Phone)

_____

_____

_____

EMPLOYMENT/INSURANCE/UNION MEMBERSHIP

Primary Employer _____ Address _____

Wage _____ _____

_____

Insurer _____ Adjuster _____

Address _____ Claim No. _____

_____ Telephone _____

Managed Care Organization ☐ Yes ☐ No Policy No. _____

When was the comp insurer notified of the claim being filed? Date _____

Date of Hire _____ Occupation _____

Currently Working _____ Scheduled Days Off _____

Wage Loss Paid _____

Secondary Employer _____ Address _____

Wage _____ _____

_____

Insurer _____ Adjuster _____

Address _____ Claim No. _____

_____ Telephone _____

Managed Care Organization ☐ Yes ☐ No Policy No. _____

When was the comp insurer notified of the claim being filed? Date _____

Has documentation of the wage at the secondary job been obtained? ☐ Yes ☐ No

Date of Hire _____ Occupation _____

Currently Working _____ Scheduled Days Off _____

Wage Loss Paid _____

Non-Industrial Carrier ☐ Yes ☐ No Policy No._____
Carrier_____
Address_____

Private Health Carrier (if any) ☐ Yes ☐ No Policy No._____
Carrier_____
Address_____

Union Membership ☐ Yes ☐ No Local No._____
Union Name_____

INJURY

Date of Injury_____ Claim No._____
WCB No._____ WCD No._____
Body Part(s) Injured

How Did the Injury Occur

Where Did the Injury Occur (City/State)

PRIOR CLAIMS

Date of Prior Workers' Comp Claim_____ Amount of Award $_____
Date of Prior Workers' Comp Claim_____ Amount of Award $_____
Date Worker's Statement or Deposition Taken_____

PREVIOUS MOTOR VEHICLE ACCIDENTS AND OTHER PRIOR INJURIES

MEDICAL CONDITIONS PRE-EXISTING THIS INJURY

PRIOR ARRESTS AND CONVICTIONS

MENTAL HEALTH, ALCOHOL, DRUG USE (CURRENT AND HISTORY)

DEADLINES TO CALENDAR

Date of Notice of Closure_____ Statute Runs_____
60 days from date of Order

Date of Reconsideration Order***** _____ Statute Runs_____
30 days from date of Reconsideration Order

Date of Denial* _____ Statute Runs_____
60 days from date of mailing of denial

Aggravation Claim_____ Statute Runs_____
5 years from date of first Notice of Closure, if disabling;
5 years from date of Notice of Acceptance, if nondisabling

*** Request hearing immediately**

Date of Opinion and Order_____ Statute Runs_____
30 days from date of Opinion and Order

Date of Board Order Mailing_____ Statute Runs_____
30 days from date of Order on Review

Date Appellate Brief Due_____

Date of scope of acceptance demand letter _____ Statute Runs_____
60 days from date of demand

Date of Director's Admin. Review Order_____ Statute Runs_____
60 days from Dir. Admin. Review Order

Date of Medical Services Order_____ Statute (OAR) Runs_____

Vocational Services Issue_____ Statute Runs_____

WCD

Date Request for Hearing Filed_____
Hearing Date_____
Date Client Notified_____

WCB

Date Request for Hearing Filed_____
Hearing Date_____
Date Client Notified_____

LIEN ITEMS

☐ Child Support Liens ☐ Unemployment Benefits ☐ Social Security Disability

☐ Medicaid ☐ Medicare ☐ Oregon Health Plan

☐ Welfare Assistance ☐ Private Health Carrier ☐ Other _____

NAMES OF PHYSICIANS, MEDICAL FACILITIES WHERE TREATED

Physician or Facility	Address	Phone

REQUESTS FOR RECORDS

Records from treating physician	Date Requested_____	Rec'd_____
Hospital records	Date Requested_____	Rec'd_____
Other physician records	Date Requested_____	Rec'd_____
Other physician records	Date Requested_____	Rec'd_____
Document demand to employer	Date Requested_____	Rec'd_____
Medical releases obtained	Date Requested_____	Rec'd_____

THIRD PARTY RESPONSIBILITY

Third Party Potential _____

Potentially Responsible Party _____

Theory of Liability _____

SOL _____

Notes _____

_____

_____

_____

_____

_____

WITNESSES

	Interviewed	Subpoenaed
Name _____	☐	☐
Address _____		
_____		
Telephone _____		
Name _____	☐	☐
Address _____		
_____		
Telephone _____		
Name _____	☐	☐
Address _____		
_____		
Telephone _____		
Name _____	☐	☐
Address _____		
_____		
Telephone _____		

IMPORTANT NOTICES