WILLIAM A. HERRERAS
ATTORNEY AT LAW

709 E. Grand Avenue
Arroyo Grande, CA 93420
(805)473-8550

Mailing: P.O. Box 1668
Arroyo Grande, CA 93421
FAX (805)473-8583

The date and time of your scheduled appointment is:
Please bring this questionnaire with you, completed, at the time of your conference.

WORKERS' COMPENSATION QUESTIONNAIRE

DATE: REFERRED BY: UNION:
ATTORNEY OR PERSON:

NOTE: IF YOU NEED MORE SPACE TO ANSWER THAN THE FORM PROVIDES, PLEASE USE SEPARATE PAPER, NOTING QUESTION NUMBER, AND ATTACH IT TO THIS FORM.

PART I - GENERAL INFORMATION

1. Full Name: (Mr. Mrs. Ms.)
2. Street address: City/Zip
3. Telephone: Home Work Message
4. Birthdate: Spouse's name:
   SS#
   Email:
   Nearest relative/friend:
   Address: Phone:
5. Do you have Medi-Cal? Yes No If yes, Medi-Cal No:
6. Do you have a Facebook or other social media account? Yes No

PART II - EMPLOYER INFORMATION (Employer at time of injury/illness)

7. Employer:
   Street address: City/Zip
   Telephone Number:
8. Date of hire: Job title:
   Pay rate: No. hours/week:
   Description of job duties:

   Have you been terminated or laid off from this job? Yes No
   If YES, please explain:

   Last Day BEFORE the injury that you worked:
9. Overtime work? Yes No
   If YES, were you paid 12 for overtime? Yes No
   Actual earnings at time of injury:
   Were you entitled to automatic raises or cost of living increases?
   Yes No If YES, please explain:

10. If you belong to a Union, list name and location:

11. Are you interested in returning to the same job? Yes No
12. If necessary, are you interested in a modified job with the same employer. Yes No
13. Do you know if your employer would consider job modification? Yes No
14. Did you complete the Workers' Compensation Claim Form and give it to your employer? Yes Date: No
    If YES, please bring a copy of the Claim with you.
15. Did your employer answer (complete bottom portion of form) and return a copy to you marked "Employee's Copy"? Yes No
16. Did your employer, or their workers' compensation carrier or agent, advise you of your rehabilitation rights? Yes Date: No
17. If you are going to a doctor for this work injury, was the doctor selected by your employer? Yes No
18. Was the doctor selected by you? Yes No
19. Are you a member of a Medical Provider Network, HCO or ADR? Yes No
20. Did you PREdesignate a physician with your employer if a workers' compensation injury were to occur? Yes No
    If yes, name of doctor
21. Do you have objections to changing to a doctor of our choice? Yes No
22. Have you given a statement about your injury to anyone other than your doctor? Yes No
    If YES, please identify:
23. If your injury involved an accident on the job, was Cal-OSHA notified? Yes No If yes was a report prepared? Yes No

PART III - OTHER EMPLOYERS*

24. Did you have a second job at the time of injury? Yes No
25. Do you have a second job now? Yes No
    If YES, what are your earnings?
26. Current employer:
    If working, date of return to work:
    If not working, last date worked:
27. Other employer in past year:
    Name:
    Address: City/Zip
    Job Title: Date of hire:
    Pay rate: No. hours/week:
    *Bring a copy of your last pay stub and W2 for that employment.

PART IV - INJURY/ILLNESS INFORMATION

28. Have you consulted another attorney about this injury/illness prior to today? Yes No
29. Date of injury/illness:
    (If there is more than one date, please list)
    Place: Time:
30. Parts of body injured:

31. Type of Injury:
32. How did injury/illness occur?

33. Responsibility for injury/illness:
    Employer Fellow employee Unsafe Condition
    Machine Chemical Substance Someone else
    Please explain if you "X" one or more of the above:

PART V - MEDICAL TREATMENT FOR INJURY/ILLNESS

34. List present treating doctor(s), date(s) last seen and nature of treatment:
    a. Dr. Address:
       Date last seen:
       Treatment:

    b. Dr. Address:
       Date last seen:
       Treatment:

35. List all other doctors/hospitals seen for the injury/illness:
    Name Address Date last seen

36. Were you hospitalized overnight? Yes No
37. Who do you believe is your treating doctor:

PART VI - INSURANCE INFORMATION

38. Name of workers' comp. ins. co.:
    Address: Phone:
    Name of claims adjuster: Claim No:
39. Do you have medical insurance? Yes No
    If YES, name:
40. Who paid for your medical treatment?
    Workers' Comp. Ins. Co. Your own medical insurance
    Medi-Cal Yourself
41. Please list all unpaid medical bills related to the injury/illness and all medical bills paid by you and nobody has reimbursed you:
    Unpaid Paid by you (not reimbursed)

PART VII - INFORMATION FOR CALCULATION OF DISABILITY BENEFITS*

42. Periods you did not work due to this injury/illness:

from to
from to
from to
from to

Periods you received workers' compensation benefits:

from to
from to
from to
from to

Weekly rate:

43. Have you applied for State Disability: Yes No

44. Benefits received from other sources:

	Dates	Amounts
a. State Disability		
b. Unemployment		
c. Social Security		
d. Long-Term Disability		
e. Retirement/pension		
f. IDL (State employees only)		
g. NDI (State employees only)		
h. Other:		

45. Regarding Social Security:

1. Are you receiving social security or have you applied for social security? Yes No if so, when?

2. Are you receiving social security benefits for a disabled son or daughter, child or adult, that you are providing care for? Yes No If so, any settlement of your workers' compensation case may affect these benefits.

*Bring a copy of last three (3) years W2 forms (years prior to injury/illness).
*Bring a copy of your last pay stub prior to injury/illness.

PART VIII - OTHER INJURIES/ILLNESSES

46. Have you had any other on the job injuries/illnesses? Yes No

Dates	Parts of body injured	How occurred	Fully recovered

47. Have you had any other off the job injuries/illnesses? Yes No

Date	Parts of body injured	How occurred	Fully recovered

48. List names, addresses and dates of all doctors/ hospitals seen for each of the above injuries/illnesses: (Questions #41 & 42)
    Dates Doctors/Hospitals Address

49. Have you ever filed a claim or lawsuit for a work injury or personal injury? Yes No If YES, please explain:

50. Do you have any other medical conditions? Yes No
(Example: heart disease, arthritis, emphysema, loss of vision, hearing loss, breathing problems):

51. Doctors/Hospitals seen for the above medical conditions: (Question #45):
    Dates Doctors/Hospitals Address

Notes: _____
_____
_____
_____

PART IX - JOB REHABILITATION OR RETRAINING

52. Do you believe that your job related injury/illness prevents you from doing your job? Yes No

53. If YES, please describe, in detail, what job duties you believe you cannot perform: (If you need more space to answer than the form provides, please use reverse side of form, noting question number):
    _____
    _____
    _____
    _____
    _____

Dated: _____

Please sign your name: _____

- -

Has your treating doctor, or any other doctor, advised you that you cannot return to your job? Yes No

If YES, please provide us with the name and address of your doctor:

Dated:_____

Please sign your name:_____

ATTORNEY USE ONLY

Group # **TO BE COMPLETED BY ATTORNEY**

Third Party: Yes No Discussed with client: Yes No

Serious & Willful: Yes No Discussed with client: Yes No

132(a) Yes No Discussed with client Yes No

SS: Yes No Date Eligible Discussed with client: Yes No

Client to bring in additional information: (1) _____

(2) _____ (3) _____ (4) _____