

## WORKERS' COMPENSATION CARRIER SUPPLEMENTAL QUESTIONS

DO YOU HAVE A WRITTEN JOB DESCRIPTION?

DUTIES:

HOURLY RATE/HRS WORKED/PAID HOURLY OR SALARY/ RECEIVE TIPS OR COMMISSION?

CONCURRENT EMPLOYMENT?

PRIOR EMPLOYMENT?

DOMNINANT HAND?                    **RIGHT**                    **LEFT**

IS THERE SURVEILLANCE VIDEO?                    **YES**                    **NO**

TREATING DOCTOR INFORMATION:

AMBULANCE?                    **YES**                    **NO**

DOES EMPLOYER HAVE ANY REASON TO QUESTION OR DOUBT THE VALITY OF THE CLAIM? YES/NO  
EXPLAIN:

INTERNAL INVESTIGATION COMPLETED?                    **YES**                    **NO**    DRUG TESTED?                    **YES**                    **NO**

CAN YOU ACCOMODATE MODIFIED/LIGHT WORK?                    **YES**                    **NO**

WAS THE INJURED WORKER PAID FOR THE FULL DAY ON THE DATE OF INJURY?                    **YES**                    **NO**

ANY PERSONAL ISSUES?                    **YES**                    **NO**                    GOOD EMPLOYEE?                    **YES**                    **NO**

PRIOR INJURES/CLAIMS/HEALTH CONDITIONS?

ANY SUBROGATION POTENTIAL? FAULTY MACHINARY/ OTHER PERSONS INVOLVED?

OVERWEIGHT?                    **YES**                    **NO**                    SMOKER?                    **YES**                    **NO**

ACTIVITIES/HOBBIES OUTSIDE OF WORK THAT COULD RESULT IN INJURY OR ACCIDENT?

PLEASE PROVIDE NAME & PHONE NUMBER OF SUPERVISOR:

**Additional notes or  
Comments:**

---



---



---



---



---