pennsylvania
DEPARTMENT OF LABOR & INDUSTRY

STATE WORKERS' INSURANCE FUND

Injured Worker's Statement

Claim Number: ______________

1. Name: ______________________________
2. Address: ______________________________

____

3. Phone number: ______________________
4. Date of birth: ______________________
5. Social Security number: ______________________
6. Marital status: ☐ Single ☐ Married ☐ Divorced ☐ Domestic Relations
7. Any children under the age of 18? ☐ Yes ☐ No
8. If Yes, name(s) and age(s): ______________________________

____

____

9. Name and address of employer: ______________________________

____

____

10. Injured worker's date of hire: ______________________________
11. Injured worker's job title: ______________________________
12. Description of injured worker's duties: ______________________________

____

____

13. Salary: ____________ per ______________ Number of hours/days:
14. Shift worked/starting time: __________ ☐ AM ☐ PM
15. Concurrent employment at time of injury: ☐ Yes ☐ No
16. If Yes, name and address of employer: ______________________________

____

____

17. Date and time of Injury: ______________________________ ☐ AM ☐ PM
18. Who did the injured worker report the injury to? ______________________________
19. Person's title/position: ______________________ Date Reported: ______________
20. Name(s) of Witness(es): ______________________ Phone No.: ______________

______________________ Phone No.: ______________

______________________ Phone No.: ______________

21. Detailed description of the injury:

A. What was the injured worker doing prior to the injury? ______________________________

____

____

____

____

B. What exactly was the injured worker doing at the time of the injury?

____

____

C. What specific tools or equipment was the injured worker using at the time of the injury?

____

D. In the injured worker's words, describe the occurrence of the injury:

____

____

____

____

____

22. Nature of injury/diagnosis: ______________________________

____

23. Name and address of the initial physician? Hospital: ______________________________

____

____

24. Has the worker been referred to another physician? ☐ Yes ☐ No

25. If Yes, name and address of physician: ______________________________

____

____

26. Has the injured worker been treated for this type of injury previously? ☐ Yes ☐ No

27. If Yes, when? ______________________________

28. Cause of previous injury: ______________________________

29. Name and address of previous treating physician: ______________________________

____

____

30. Is there any information the injured worker would like to add to this statement? ______________________________

____

____

THE INFORMATION I HAVE GIVEN ON THIS STATEMENT IS TRUE AND CORRECT TO THE BEST OF MY KNOWLEDGE.

Injured Worker's Signature: ______________________________ Date: ______________

Adjustor's Signature: ______________________________ Date: ______________

CLAIMANT'S DESCRIPTION FORM

NAME:_______________________________

CLAIM #_________________

PHYSICAL CHARACTERISTICS

SEX: _________________ RACE: _____________ AGE: ______________

HEIGHT: ______________ WEIGHT: ___________ HAIR COLOR: _______

EYE COLOR: ___________ GLASSES: YES_____ NO______

IDENTIFYING MARKS:
____
____

DO YOU HAVE A CAR? YES______ NO______ PLEASE GIVE DESCRIPTION OF CAR, YEAR, COLOR AND MAKE.

YEAR: _____________ COLOR:_________________ MAKE:_________________

DO YOU LIVE IN AN APARTMENT OR HOUSE? _____________________________________

IF YOU LIVE IN A HOME, PLEASE GIVE A BRIEF DESCRIPTION:
____
____
____

DATE: _______________________________

NAME: _______________________________

State Workers' Insurance Fund
444 North 3rd Street, 6th Floor | Philadelphia, PA 19123-4186 | 215.560.1860 | F 215.560.2951 | www.dli.state.pa.us

Auxiliary aids and services are available upon request to individuals with disabilities.
Equal Opportunity Employer/Program

pennsylvania
DEPARTMENT OF LABOR & INDUSTRY

STATE WORKERS' INSURANCE FUND

Doctor's Initial Report

IMPORTANT: Complete this form and return it to the ______________________________

______________________________ promptly after first treatment and diagnosis.

CLAIM NO. ______________

Name ______________________________ Age

Residence ______________________________

Employer ______________________________

Address ______________________________

Occupation ______________ Sex ☐ M ☐ F ☐ Single ☐ Married ☐ Divorced

1. Date of accident ______________ Place of accident ______________
2. Description of accident ______________________________
3. When and where first seen by Physician? ______________________________
4. Describe fully the precise nature and extent of injuries received; also, the exact appearance and localities of same.

   Do you feel that the employee's injury is a result of his/her employment? ☐ Yes ☐ No
5. Was an X-ray taken? ☐ Yes ☐ No If Yes, give findings ______________________________
6. What treatment was given? ______________________________
7. Was any previous treatment given? ☐ Yes ☐ No If Yes, by whom? ______________ Date ______________
   Is there any history and evidence present of pre-existing injury or disease? ☐ Yes ☐ No
   If Yes, what? ______________________________
8. Was Claimant referred to another individual for additional medical treatment and/or consultation? ☐ Yes ☐ No
   If Yes, who and for what purpose? ______________________________
   If hospitalized, state on whose authority and give name and address of hospital.
9. Has injured resumed work? ☐ Yes ☐ No
   If No, when will injured likely be able to resume work? ______________ In what capacity? ☐ Light duty ☐ Full duty
   Date last treated and condition at that time. ______________________________

Date of this report ______________ Print Doctor's Name ______________________________ M.D.

Signature ______________________________ M.D.

Address ______________________________

City and State ______________________________ Zip Code ______________

Internal Revenue Identifying Number ______________________________

SWIF-137 REV 7-09