

**KEARNEY ORTHOPEDIC AND SPORTS MEDICINE**  
**Injuries from the Job**

Patient Name \_\_\_\_\_ Date \_\_\_\_\_

1. My workers' compensation injury occurred on (date) \_\_\_\_\_. When I was working for (employer's name) \_\_\_\_\_, in the city of \_\_\_\_\_
2. My job at that time was (job description) \_\_\_\_\_
3. The specific details of my injury are (please include body part that was injured and indicate whether right or left: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
(a) I have injured this body part before. Yes \_\_\_\_\_ No \_\_\_\_\_  
If yes, give details \_\_\_\_\_  
I have received the following treatment for this injury to date \_\_\_\_\_
4. My employer is aware of my injury. Yes \_\_\_\_\_ No \_\_\_\_\_
5. I have filed a report with my employer. Yes \_\_\_\_\_ No \_\_\_\_\_
6. To my knowledge my employer and I are in agreement that my injury is being covered by my employer's workers' compensation. Yes \_\_\_\_\_ No \_\_\_\_\_
7. Because of my injury, I was unable to work on these dates: \_\_\_\_\_
8. I am currently working for the same employer: Yes \_\_\_\_\_ No \_\_\_\_\_
9. If you are NOT working at this time, when did you last work? \_\_\_\_\_  
If the dates are approximate, please mention that this is so. \_\_\_\_\_  
(a) Who instructed you to discontinue working?  
self \_\_\_\_\_ doctor \_\_\_\_\_ employer \_\_\_\_\_ other \_\_\_\_\_  
(b) Are you able to return to your former job? Yes \_\_\_\_\_ No \_\_\_\_\_  
(c) Are you able to work in light duty capacity? Yes \_\_\_\_\_ No \_\_\_\_\_  
(d) Have you been given a target date for your return to work?  
Yes \_\_\_\_\_ No \_\_\_\_\_; If yes, what date? \_\_\_\_\_
10. Does your employer have a light duty status? Yes \_\_\_\_\_ No \_\_\_\_\_
11. Have you ever had a determination of disability for this injury? Yes \_\_\_\_\_ No \_\_\_\_\_
12. Have you seen any other doctors for this injury? Yes \_\_\_\_\_ No \_\_\_\_\_ If yes, how many? \_\_\_\_\_
13. Who sent you to Kearney Orthopedic and Fracture Clinic? \_\_\_\_\_
14. Are you in a legal dispute regarding your condition? Yes \_\_\_\_\_ No \_\_\_\_\_
15. Have you enlisted the services of a lawyer for any aspect of your condition? Yes \_\_\_\_\_ No \_\_\_\_\_
16. Are there any questions that are confusing or require further explanation on your part?  
Yes \_\_\_\_\_ No \_\_\_\_\_; Please explain: \_\_\_\_\_

The above statements are true and complete to the best of my knowledge. I understand that although you process insurance claims for me, you cannot guarantee payment, coverage, or particular benefits. If workers' compensation denies this claim, I agree to pay for all charges.

Date: \_\_\_\_\_ Signature: \_\_\_\_\_

Note to our patients: Sometimes a patient who is injured on the job has a separate problem which he would also like evaluated and/or tested by our doctors but is not related to his job. The clinic must bill you or your medical insurance carrier for that non-job related problem. We do not bill the Workers' Compensation carrier for non-job related problems. I have read and understand this paragraph.

Date: \_\_\_\_\_ Signature: \_\_\_\_\_