David Gilboe and Associates, P.C. 23161 Greater Mack, St. Clair Shores, MI. 48080
(586) 779-8892 Fax (586) 779-2869.

Workers Compensation Injury Questionnaire

Patient name:_____Date:_____

Have you sustained injury to more than one area of your body? ☐Y ☐N
Date of Injury_____
Part of the body injured._____
Case number for the listed injury_____

Are you currently working?☐Y ☐N

Employer name and address: _____

Have you contacted an attorney? ☐Y ☐N
If yes, the attorneys name and telephone number._____

(_____)_____

I understand the provided information to be true and accurate to the best of my knowledge. I understand that if I have not provided the correct claim and injury information, my claim will be denied. If my claim is denied for this reason, I am responsible for cooperating to make any necessary changes or to pay the balance of the account.

Patient signature: _____

If you have any questions pertaining to your rights contact:
Bureau of Workers & Unemployment Compensation Act
@ 1 (888)-396-5041.