This information shall be prepared in triplicate and will be deemed employee's exhibit #1.

EMPLOYEE BIOGRAPHICAL DATA

All information is to be filled in **completely** and prepared prior to hearing. A copy is to be provided to opposing counsel and offered in evidence as if so testified.

Name of Claimant/ Employee

Address

Date U.S. domicile established

Place of birth Date of birth

Marital status Spouse's name Spouse's occupation

Name & ages of children

EDUCATION:

Name & address of last school attended

Highest grade completed

List any special training or skills

EDUCATION & SCHOOLING:

Please tell us how far you went in school (highest grade you completed)_____

HIGH SCHOOL:

Did you attend high school? _____

Which one? _____

Did you graduate? _____

When? _____

What kind of degree did you obtain? _____

Academic_____

Vocational_____

GED_____

Other_____

FURTHER EDUCATION:

Did you obtain further education? _____

Where? _____

When? _____

What degree, if any, did you obtain? _____

_____

SPECIAL TRAINING:

In addition to what you have previously testified, have you received any special training?

_____

If so:

Where? _____

When? _____

What did the training consist of?

_____

_____

_____

_____

MILITARY SERVICE:

Where you ever in the military? _____

When? (from: _____ to: _____)

What branch? _____

What special training, if any, did you receive?

_____

_____

_____

WORK EXPERIENCE:

After you finished school, did you obtain employment? _____

Please describe the job(s) that you have held, including employer, dates of employment, and a brief description of your job, title and duties starting with the first job you held.

Develop Chronologically

Employer: _____

From: _____ to: _____

Job title: _____

Job duties: _____

_____

Employer: _____

From: _____ to: _____

Job title: _____

Job duties: _____

_____

Employer: _____

From: _____ to: _____

Job title: _____

_____

Job duties: _____

_____

Employer: _____

From: _____ to: _____

Job title: _____

Job duties: _____

_____

Employer: _____

From: _____ to: _____

Job title: _____

Job duties: _____

_____

Employer: _____

From: _____ to: _____

Job title: _____

Job duties: _____

_____

_____

HOBBIES:

Prior to (date of injury) _____ what hobbies or recreational activities, if any, did you participate in?

_____

_____

_____

Civic involvement: _____

Church involvement: _____

Sports: _____

PRIOR MEDICAL PROBLEMS:

(Use to diffuse cross- examination)

Prior to (date of injury) _____ what physical and/ or emotional problems, if any, did you suffer from?

	Condition	Treatment	Doctor
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____

_____

Other prior problems/ accidents:

_____

_____

_____

INCIDENT:

On (date of injury) _____ by whom were you employed? _____

_____

AVERAGE WEEKLY WAGE:

How much were you making per week, gross salary: _____

Yearly salary: _____

(Note: Introduce pay stubs or other evidence if A/W/W is contested.)

JOB DESCRIPTION:

What was your job title? _____

What did your job actually consist of (i.e. what did you do)? _____

_____

_____

_____

What, if anything, happened on (date of injury) _____?

_____

SPLICE IN HISTORY:

(Leave rest of page blank to splice story.)

How did you feel after the accident (describe)? _____

_____

_____

_____

REPORT OF ACCIDENT:

What, if anything, did you do next (describe who accident was reported to)? _____

_____

Was an Accident Report completed? _____

By whom? _____

(Note: If available, introduce.)

WORK ATTEMPTS:

After (date of injury) _____ did you return to work the next day? _____

If no, why not? _____

If yes, how were you feeling? _____

Where you able to continue working? _____

If no, why not? _____

What additional attempts, if any, did you make to return to work? _____

_____

When was the last date that you worked? _____

How were you feeling? _____

_____

MEDICAL ATTENTION:

As a result of your accident at work on (date of injury) _____ did you seek medical attention? _____

_____

(Note: If objection, re-phrase. *As a result of the medical problems you have just described, did you seek medical attention?*)

_____

Please describe the doctors that you saw, when you saw them, and what, if anything, they did for you.

	Date	Doctor	What they did
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____
6.	_____	_____	_____

HOSPITALIZATION:

Did there come to be a time in your treatment when you were hospitalized for this condition? _____

How were you feeling just prior to your admission? _____

_____

Describe:

	When	What hospital	What, if anything, did they do for you?
1.	_____	_____	_____

_____

2. _____ _____ _____

3. _____ _____ _____

4. _____ _____ _____

How were you feeling after you discharge (describe problems)? _____

_____

_____

(Leave rest of page blank for splicing chronological list of medical care.)

MEDICATIONS:

What medications, if any, have been prescribed for you?

1. _____ 2. _____

3. _____ 4. _____

5. _____ 6. _____

Did you take these medications? _____

Did they help you? _____

What problems, if any, have you had with these medications?

Medication	Problems
1. _____	_____
2. _____	_____
3. _____	_____
4. _____	_____
5. _____	_____
6. _____	_____

RETURN TO WORK:

Have you returned to your old job since (last day worked) _____? _____

Why not (describe in detail)? _____

_____

_____

_____

_____

REHABILITATION:

(Note: Flesh out if helpful.)

What, if anything, have you done in the way of rehabilitation? _____

_____

What have they done for you? _____

_____

Have you completed the evaluation process? _____

What remains to be done? _____

_____

PHYSICAL THERAPY:

(If helpful)

What, if anything, have you done in the way of physical therapy? _____

_____

Where? _____

How often? _____

Did it help? _____

Is it still going on? _____

Other: _____

_____

OTHER INCOME:

(If helpful to show total disability)

Other than workers' compensation, what income, if any, do you have (i.e. social security disability, L.T.D., etc.)? _____

_____

_____

CURRENT STATUS:

How are you feeling now (describe in detail: pain, sleeping problems, etc.)? _____

_____

_____

DOCTOR:

Are you still under active medical care? _____

By whom? _____

How often are you seen? _____

What does he/ she do for you? _____

_____

MEDICATION:

Are you currently on any medication(s)? _____

	Medication	How often taken	For what condition
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____

HOBBIES & RECREATION:

Are you able to partake in your usual hobbies and recreational activities, sports, etc.? _____

Why not? _____

_____

AVERAGE DAY:

Please describe what you normally do during the day: _____

_____

_____

_____

What about sleeping? _____

_____

WORK:

Are you currently able to return to your old job? _____

Are you able to return to any work? _____

Why not? _____