Mt. Vernon Spine & Disc Center

4200 Williamson Place Suite 2B
Mt. Vernon, IL 62864
ph: 618-242-8100 fax: 618-242-8101

Worker's Comp Incident Form

Patient Name _____ **Today's Date** _____

Name of Compensation Carrier: _____.

Name of Employer: _____.

The date of the work related injury was: _____.

The time that the injury occurred was: _____ **a.m. / p.m.**

The last date worked was: (month)_____**/ (day)**_____**/(year)**_____.

Were you hospitalized? Yes No. If yes, please answer the questions below.

When were you hospitalized? immediately later same day next day date _____

How were you transported to the hospital? ambulance life flight private transportation

What did the hospital recommend? no instructions see this clinic see DC
see own doctor see orthopedist see neurologist prescription medication
other: _____

Did you have any xrays taken? Yes No
If yes, what areas? _____

My current job status is: (please mark the appropriate response below)
off work as a result of the injuries sustained in the reported work accident.
working full duty.
working light duty.

I have have not been involved in previous work related accidents/injuries.

If you have been involved in previous work related accidents/injuries, please complete below.

Status of previous injuries:
treated and resolved
treated, unresolved, and located at an unrelated area to this accident
treated, unresolved, same area as current injury
not treated and a completely different area than current injury
not treated and still have residual symptoms
not treated and do not have any residual symptoms

This accident was: not reported to the employer. reported to the employer.

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The name of the employee it was reported to was: _____.

Employee's Job Title _____ Phone # _(_____)_____-_____.

The injury occurred at (location): _____.

How many hours did you work that same day prior to the accident: _____.

What type of work were you performing at time of injury: _____
_____.

Describe the accident: _____
_____
_____
_____.

I have:

been treated by another doctor for the injuries sustained in this accident.
not been treated by another doctor for the injuries sustained in this accident.

If you have been treated by another doctor, please continue with the following questions.
List the doctor's name and current/past treatment: _____
_____
_____.

As a result of the treatment received thus far:

My condition has improved
My condition has not improved
My condition has worsened since the injury despite treatment received thus far.