

Kaiser On-the-Job®

INITIAL	INIDHISTRIAL	VICIT	\bigcirc	VIVIVIDE

To be completed by the injured worker at the initial visit for an industrial injury or illness

MR #:			
Name:			

	y or illines							
PLEASE PRINT				IMPRINT AREA				
		YOUR INFOR	MATION					
LAST NAME	FIRST NAM	1E	SEX M	BIRTH DAT	E	SOCIAL SE	ECURITY#	
HOME ADDRESS			CITY				STATE, ZIP	
HOME PHONE		OTHER PHONE			WORK PHO	ONE		
JOB TITLE OR DESCRIBE THE TYPE OF WORK	YOU DO				1		ARE YOU A LONGSHOREMAN? Yes No	
		EMPLOYER INF	ORMATIO	ON				
COMPANY NAME		SUPERVISOR/CONTACT			SUPERVIS	OR/CONTAC	CT PHONE	
ADDRESS			CITY				STATE, ZIP	
		ABOUT YOUR INJUR	Y OR IL	LNESS				
WHERE WERE YOU WHEN YOU BECAME INJUR	RED OR ILL? (SS)			
DATE YOU WERE INJURED OR BECAME ILL		TIME		□ AM □ PM	MOST REC	CENT DATE V	VORKED	
HAVE YOU REPORTED THIS AT WORK? Yes No		ALL INJURED WORKERS MUST CO FOR WORKERS' COMPENSATION I HAVE YOU COMPLETED AND RETU	BENEFITS (FC	RM DWC-1)		ER? Y	es 🗆 No	
HAVE YOU SEEN A KAISER DOCTOR FOR THIS HAVE YOU SEEN ANY OTHER DOCTOR FOR TH HOW DID YOU BECOME INJURED OR ILL? DESC	IIS INJURY O	RILLNESS? Yes No	IF YES, WH		-ED			
Any person who makes or cau representation for the purpose								
SIGNATURE						DATE SIGN	NED	
FOR OFFICE USE ONLY: INSURANCE VERIFICA	ATION					1		