Frank B. Watkins

Attorney and Counselor At Law
A Professional Corporation

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WORKERS' COMPENSATION INTAKE INFORMATION

Date: _____ File No. _____
(Office use only)

YOUR INFORMATION

Name: _____
Physical Address: _____
Mailing Address: _____
City, State, Zip: _____
Home Phone: _____
Work Phone: _____
Cell Phone: _____
Employer: _____
Date of Birth: _____
Spouse: _____

List treating doctors including primary health care provider

Doctor: _____
Doctor Address:_____
_____
Doctor: _____
Doctor Address:_____
_____
Doctor: _____
Doctor Address:_____
_____

Date of Injury:_____
Final Determination Date: _____
What was injured (arm/shoulder/back): _____
_____

Physical Therapy: _____
Address: _____
Physical Therapy: _____
Address: _____

List all witnesses:

Name _____
Address _____
Phone _____

Name _____
Address _____
Phone _____

Name _____
Address _____
Phone _____

Name _____
Address _____
Phone _____

I understand that unless the attorney and I sign a representation agreement the law firm of Frank B. Watkins does not represent me.

_____
(Signature)

OFFICE USE ONLY

Conflict of Interest Cross Check:

	YES	**NO**
Client List:	_____	_____
Adverse Party:	_____	_____
Frank Watkins:	_____	_____
Other:	_____	_____
Abacus:	_____	_____
Index Card:	_____	_____

TO-DO	**YES**	**NO**
Get Appointed	_____	_____
Received Order	_____	_____
Letters to Drs.	_____	_____

Send Discovery to: Employer_____ Division_____