ICA 04-0521-87

Claimant's Name:

WORKER'S SUPPLEMENTAL CLAIM FORM

Do not complete this form before_____and return to

THE INDUSTRIAL COMMISSION OF ARIZONA
NO-INSURANCE SECTION
P.O. BOX 19070
PHOENIX, AZ 85005

Claim No:

Injury Date:

This form must be fully completed and signed by you (and your attending physician if you are presently under medical care). No person will be ordered to work without a report by attending physician.
PAYMENT OF COMPENSATION CANNOT BE MADE UNTIL THIS CLAIM FORM IS RECEIVED. Use pen or typewriter.
THIS FORM IS FOR THE PERIOD FROM_____ THROUGH_____

IF YOU HAVE RETURNED TO WORK

MY GROSS EARNINGS FOR THE ABOVE PERIOD WERE: $_____

Name and address of Employer(s) (Include Self - Employment)	Total Amount Earned Before Deductions	Period of Employment (From – Through)
_____	$ _____	_____
_____	$ _____	_____

Type of work _____Rate of Pay $_____
Do you claim to have a loss of earnings due to this industrial injury? _____
If so, you must have such loss verified as indicated on the reverse side of the form to be eligible for compensation payment

IF YOU HAVE NOT RETURNED TO WORK

Medical reports indicate that you were released as able to return to the same or a lighter type of employment as performed at time of injury. Please state full and complete reasons for your failure to return to the type of employment to which you released. _____
_____

List all employment to whom you have applied for work:

Name and Address	Date of Applied	Job Position	Name of person Taking application
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Date of last registration with Arizona State employment Service _____
(List any other employer and appropriate information on lower reverse side)
If you have received unemployment benefits during the above period of time, state the amount
$_____

By this instrument I make application for all benefits to which I may be entitled under the law and I do herby certify, with full knowledge that it is a crime to make willful, false statements to obtain compensation, that all of the above statements are true, accurate and complete.

Date of signing: _____ Sign here:_____
Give address to which mail should be sent: _____Zip_____

STATEMENT BY ATTENDING PHYSICIAN
(If applicable-see above)

Have you discharged claimant and if so, when? _____ Date last examined_____
Claimant's condition on last examination_____
Is claimant able to fully resume type of work performed at time of injury? _____If so, give date able_____
Is condition stationary? _____
Does claimant have a permanent functional impairment as a result of this industrial injury? _____If so, give percentage and anatomical location of functional impairment_____
_____
Signed this_____ day of _____ 20_____

NOTE: This report should not be completed and signed by physician prior to date indicated at top of form.

PAYMENT APPROVED_____
DATE APPROVED_____
DATE PAID_____
WARRANT NO_____

_____
ATTENDING PHYSICIAN

_____
ADDRESS PHONE

(OVER)

TO BE COMPLETED AND SIGNED BY EMPLOYER
(If applicable-see reverse)

Total GROSS earnings before deductions from (date) _____

Through _____ Amount $ _____

If there was any loss of earnings during the period, was it due to the industrial injury? _____

If not due to industrial injury, please indicate below the reason for the loss:

_____ Claimant returned to work in a position at a lower rate of pay.
_____ Lack of available work.
_____ Lack if overtime work.
_____ Medical care not related to injury.
_____ Personal, economic, or other reason (explain below)

_____
_____
_____

Rate of pay for above earnings: Monthly $_____Weekly $_____Daily $_____Hourly $_____

Date of return to work or date of hire: _____

Type of work performed: _____

Working ability: _____

Describe any disability noted: _____

_____ _____
Date Name and Address of Employer

By _____
Title

IMPORTANT INSTRUCTIONS TO THE CLAIMANT:

Where there is a loss of earnings due to the industrial injury: To expedite payment of compensation, it will be necessary that you and each employer for whom you have worked as reported on the reverse side of this form, furnish this Commission with a signed statement indicating the actual period worked and the total earnings for such work. If this is impossible, state reasons below. Otherwise, it will be necessary to withhold payment of compensation until such time as this Commission is able to obtain such information verifying your earnings. Claimant's additional comments here: _____

_____

_____

_____

THE INDUSTRIAL COMMISSION OF ARIZONA