**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

Claimant’s Name:  

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_________________________

<table>
<thead>
<tr>
<th>IF YOU HAVE RETURNED TO WORK</th>
<th>IF YOU HAVE NOT RETURNED TO WORK</th>
</tr>
</thead>
<tbody>
<tr>
<td>MY GROSS EARNINGS FOR THE ABOVE PERIOD WERE: $</td>
<td>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.</td>
</tr>
<tr>
<td>Name and address of Employer(s)</td>
<td>Name and Address</td>
</tr>
<tr>
<td>(Include Self - Employment)</td>
<td>Date of Applied</td>
</tr>
<tr>
<td>Total Amount Earned</td>
<td>Job Position</td>
</tr>
<tr>
<td>Before Deductions</td>
<td>Name of person</td>
</tr>
<tr>
<td>Rate of Pay $</td>
<td>Taking application</td>
</tr>
<tr>
<td>Period of Employment</td>
<td></td>
</tr>
<tr>
<td>(From – Through)</td>
<td></td>
</tr>
</tbody>
</table>

Type of work ___________________________  

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.

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 hereby 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