INDUSTRIAL COMMISSION OF
ARIZONA

WORKER'S SUPPLEMENTAL CLAIM FORM

Claimant's Name:

Do not complete this form before_________________________and return to

Claim No:

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

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 an attending physician.
PAYMENT OF COMPENSATION CANNOT BE MADE UNTIL THIS CLAIM FORM IS RECEIVED.
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

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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

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 reasons (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: ____________________

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THE INDUSTRIAL COMMISSION OF ARIZONA