

19. (a) DID YOU RETURN TO WORK FOLLOWING THE INJURY?
Yes No

(b) IF SO, WHAT DATE?

20. (a) FOR WHOM DID YOU RETURN TO WORK (Give Name and Address)?

(b) AT WHAT WEEKLY WAGE?

21. NAME AND TITLE OF PERSON IN EMPLOY OF YOUR EMPLOYER WHOM YOU NOTIFIED, OR WHO HAD KNOWLEDGE OF YOUR INJURY

22. (a) DID YOU RECEIVE WORKERS' COMPENSATION BENEFITS FROM YOUR EMPLOYER OR THEIR INSURER FOR THE ABOVE INJURY?

Yes No

(b) IF SO, TO WHAT DATE?

23. WAS A NON-PREJUDICIAL AGREEMENT CONCERNING COMPENSATION BENEFITS ENTERED INTO WITH YOUR EMPLOYER OR THEIR INSURER?

Yes No

CHECK BELOW THE BENEFITS YOU ARE SEEKING

TOTAL DISABILITY COMPENSATION FROM TO

PARTIAL DISABILITY COMPENSATION FROM TO

MEDICAL BENEFITS

NO LOST TIME

NAME OF DEPENDENT SPOUSE AND NAMES AND AGES OF DEPENDENT CHILDREN AS DEFINED IN R.I.G.L. § 28-33-17.

PERMISSION TO HAVE MAJOR SURGERY PERFORMED, NAMELY:

SPECIFIC COMPENSATION CONCERNING THE FOLLOWING BODILY MEMBER (S) OR FUNCTION (S):

COUNSEL, WITNESS AND SHERIFF'S FEES

Name of Attorney

Signature of Employee

Address and Phone Number of Attorney

Date

Bar Registration Number

Signature of Attorney