EMPLOYEE ACCIDENT FORM

Return to:
Qual-Lynx
30 Knightsbridge Rd.
Piscataway NJ 08854

EMPLOYEE NAME	I.D.	Time of Injury	Date of Injury	File Number
Please List Your Primary Care Physician and his/her address for the past ten years				
Briefly describe how you got hurt and when the injury or illness occurred.				
What part(s) of the body were hurt; and in what part(s) of the body do you currently feel pain?				
Have you had treatment in the past for the same or similar medical condition? Yes ____ No _____ If yes, please provide the name and address of the treating physician(s) for this condition. List any medications you are or were taking for this condition/injury?				
Have you been treated in the past by a chiropractor? Yes____ No _____ If yes, please provide the name and address of the chiropractor(s):				
Have you filed any workers' compensation claims(s) in the past for this medical condition? Yes ____ No ____ If yes, please provide the details of the previous claim(s):				
Have you been injured in the past in any motor vehicle collisions? Yes____ No ____ If yes, please provide the details of the crash, date, and the nature of the injury and treatment:				
Do you have any outside employment? Yes ____ No ____ If yes, please list the names and addresses of these employers:				
Do you currently (in the past 12 months) participate in any athletic, recreational or sporting activities? Yes ____ No ____ If yes, please list the activities you participate in:				
To whom did you first report the injury to and when?				
Were there any witnesses to your injury? If so, who?				

I CERTIFY THAT THE ABOVE STATEMENTS MADE BY ME ARE TRUE AND CORRECT. I AM AWARE THAT IF ANY OF THE STATEMENTS ARE WILLFULLY FALSE, I MAY BE SUBJECT TO DISCIPLINARY ACTION BY MY EMPLOYER.

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize any physician, hospital or other person or institution to permit Qual-Lynx or its representative to examine, make, or be furnished with any information concerning illness or injury sustained by me including treatment, consultations, medical history, hospital records, prescriptions, diagnosis or findings. A photo static or scanned copy of this authorization shall be considered as valid as the original.

EMPLOYEE SIGNATURE	SOCIAL SECURITY #	DATE