

1. Claimant's Name \_\_\_\_\_

2. Employer UAMS \_\_\_\_\_

3. Do you desire to contest this claim?  Yes  No (Must answer this question)

4. If yes, state on what grounds? \_\_\_\_\_

5. Date of injury \_\_\_\_\_ Date Disability Began \_\_\_\_\_

6. Date of Claim \_\_\_\_\_

7. Who selected the initial physician or clinic?  Employer  Employee

8. Job Title \_\_\_\_\_

9. Wages \_\_\_\_\_

10. Additional wages (room, board furnished, if any) \_\_\_\_\_

11. Date employee left work \_\_\_\_\_

12. Has employee returned to work?  Yes  No If so, date \_\_\_\_\_

13. Did employee's wages continue while off?  Yes  No

If so, from what source?  Sick leave For how long? \_\_\_\_\_

Vacation For how long? \_\_\_\_\_

Regular Salary For how long? \_\_\_\_\_

14. Was any person other than your employee involved in the accident?  Yes  No

If so, please give details: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Name \_\_\_\_\_

Title \_\_\_\_\_

Agency UAMS \_\_\_\_\_

Phone \_\_\_\_\_

Date \_\_\_\_\_