INFORMATION FORM
How Injured Workers Suffer from SB 899

DATE: _____

PLEASE PRINT NEATLY

PLEASE COMPLETE FORM AS THOROUGHLY AS POSSIBLE.
FAX COMPLETED FORM TO: HOPCRAFT COMMUNICATIONS
916.457.5548

Injured Worker Information

- Injured Worker Name: _____
- Data on injured worker: (age, condition) _____
- Telephone (Best # to reach them at): _____ Email: _____
- Address (City, Zip Code): _____

Injury Information

- Occupation when Injured: _____ Date of Injury: _____
- Employer: _____

What is the injury/how did it happen? _____

_____

_____

- How has the new workers' compensation law (SB 899) affected your case?

_____

_____

_____

_____

_____

Ready to talk with media about case Y / N ? **Contact Lawyer Y / N?**

Attorney Information

- Attorney Name: _____
- Telephone: _____ Fax: _____ Email: _____
- Additional Notes:_____

_____

_____

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- Information Taken By: _____