Return to:
Industrial Commission of Arizona - Special Fund
PO Box 19070
Phoenix, AZ 85005-9070

NAME: _____

CLAIM #: _____

DATE OF INJURY: _____

WORKER'S SUPPLEMENTAL CLAIM FOR COMPENSATION

CLAIM FOR PERIOD _____ THROUGH _____

DO NOT SIGN, DATE AND RETURN THIS FORM BEFORE DATE SHOWN ABOVE

Have you returned to work? _____ Yes _____ No
Any self-employment? _____ Yes _____ No
⟩ If yes, answer questions in next section.

(Failure to answer these two questions will delay your benefits.)

IF YOU HAVE RETURNED TO WORK OR SELF-EMPLOYMENT THE FOLLOWING QUESTIONS MUST BE ANSWERED:

Date of return to work: _____ Job Title _____

Employer's name and address: _____

Wage: $ _____ Income from self-employment: $ _____

Date of next medical appointment _____ Doctor _____

I make application for all benefits to which I may be entitled under the law. I certify, with full knowledge, that it is a crime to make willful, false statements to obtain compensation and that all my statements on this form are true, accurate and complete.

Date Signed _____ Signature _____

Address: _____ Phone No. _____

To be completed by attending physician

How often are you seeing claimant? _____ Date last examined _____

Claimant's condition on last examination: _____

Have you discharged claimant from treatment? _____ If so, give date _____

Have you released claimant as able to return to occupation performed at time of injury? _____

If so, give date able _____

If not, have you released claimant as able to perform any other type of employment? _____

Date able _____ State any functional employment limitations _____

If condition stationary and permanent functional impairment exists, give percentage and anatomical location of permanent impairment:

Comments: _____

Date of Signing _____

_____
Attending Physician
Address: _____