DEPARTMENT OF FINANCIAL SERVICES
Division of Workers' Compensation - Bureau of Employee Assistance
200 EAST GAINES STREET, TALLAHASSEE, FLORIDA 32399-4225

REEMPLOYMENT SERVICES QUESTIONNAIRE

Personal Information

Name: ______________________ Date of Accident: ______________________

Address: ______________________ Date of Birth: ______________________

Address: ______________________

City, State ______________________ Zip Code __________ County __________

Phone # ______________________ Cell Phone # ______________________

E-Mail Address: ______________________

Preferred Method of Contact: ☐ Email ☐ Phone ☐ Mail

How did you hear about us? ______________________

1. U.S. Citizen: ☐ Yes ☐ No Resident Alien: ☐ Yes ☐ No

   Resident Alien #: ______________________

2. Primary Language spoken: ______________ Secondary Language spoken: ______________

3. Have you ever been arrested for or charged with a felony or first degree misdemeanor? ☐ Yes ☐ No

Note: The response to this question will not disqualify you from services. This information is required in order to properly assess your case and put together an appropriate reemployment plan. Approximate arrest dates are acceptable.

If you require additional space, please attach information on a separate sheet.

Date	Charge	State	County	City	Outcome

Employer & Insurer Information

Employer: ______________________ Telephone # ______________________

Address: ______________________ Fax #: ______________________

City, State, Zip ______________________ E-Mail Address: ______________________

Contact person: ______________________

WC Carrier: ______________________ Telephone # ______________________

Address: ______________________ Fax #: ______________________

City, State, Zip ______________________ E-Mail Address: ______________________

Adjuster: ______________________

REEMPLOYMENT SERVICES QUESTIONNAIRE

Claim Status & Medical Information:

1. Have you settled your claim with the Insurance Carrier? ☐ **Yes** ☐ **No**
2. What part of your body was injured as a result of your accident? ______________________

   ____

   Which side? ☐ Right ☐ Left ☐ Both

   If multiple body parts were injured, please identify the other body parts injured: ______________________

   ____
3. Do you have pending surgery/additional medical treatment(s)? ☐ Yes ☐ No

   If yes, please explain: ______________________
4. Have you been told by your Workers Compensation doctor that you will not be able to return to you previous position because of your Workers Compensation injury? ☐ Yes ☐ No
5. Have you been told by your Workers' Compensation doctor that you will have any permanent physical restrictions as a result of your Workers' Compensation injury? ☐ Yes ☐ No

   If yes, what do you understand you physical restrictions to be?

   ____
6. Have you been told by your Workers' Compensation doctor that you have reached maximum medical improvement? ☐ Yes ☐ No ☐ Don't Know
7. Do you have any other conditions that would affect your ability to return to work? ☐ Yes ☐ No
8. If yes, explain: ______________________

   ____
9. What is your dominant hand? ☐ Right ☐ Left ☐ Both

REEMPLOYMENT SERVICES QUESTIONNAIRE

Employment & Work History

PLEASE LIST EMPLOYMENT EXPERIENCE FOR THE LAST 15 YEARS.
If you require additional space, please attach information on a separate sheet.

Dates Worked	Name of Employer	Job Title	Job Duties

1. Have you returned to work? ☐ Yes ☐ No

   If no, have you talked with your employer about return to work? ☐ Yes ☐ No

   If yes, explain what happened? ______________________________

   ____

2. Have you looked for work since your injury? ☐ Yes ☐ No
3. What kinds of jobs were you looking for? ______________________________

   ____

4. Where have you looked for work? ______________________________
5. What jobs have you applied for? ______________________________
6. If you have not looked for work please explain why? ______________________________

   ____

7. Are you an honorably discharged veteran? ☐ Yes ☐ No ☐ Not applicable

REEMPLOYMENT SERVICES QUESTIONNAIRE

Educational & Transportation Information

1. PLEASE PROVIDE THE FOLLOWING INFORMATION:

   a. Do you have a high school diploma or GED? ☐ Yes ☐ No

   b. Highest Grade Completed: ____________________

   c. Major Area of Study or Certificate Earned: ____________________

2. What type of training have you received from past employers or in the military?

   ____

3. List any other special skills you possess (language, computer, etc):

   ____

Please attach copies of all diplomas and/or certificates for any type of training you have received including any received in the military. Also attach college transcripts for all classes completed.

4. What transportation is available to you? ____________________

5. Driver's License: ☐ Yes ☐ No Class: __________ Expiration Date: __________

   Suspended within the past 3 years? ☐ Yes ☐ No

   If yes, explain ____________________

I certify that to the best of my knowledge and belief all of the statements contained herein are true, correct, complete, and made in good faith.

____________________ ____________________

Injured Employee Signature **Date completed this questionnaire**