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**