

TESTER SAMPLE SIMPLES-SAMPLER
1309 CHERRY AVE
GUADELAHARA MEXICO 00000-0000

WC CLAIM NO: 9999-999999 IF YOU CALL OR WRITE US
INJURY DATE: 01/01/98 PLEASE USE WC CLAIM NO.
EMPLOYEE: SIMPLES-SAMPLER, TESTER SAMPLE
EMPLOYER: SAMPLE EMPLOYER
INSURER NO:

Voluntary Employment Status Questionnaire

Personal information you provide may be used for secondary purposes, (Privacy law, s. 15.04(1)(m)).

Dear Injured Employee:

The purpose of this questionnaire is to obtain information concerning your current employment.

If the information provided reflects that you have a need for vocational assistance as a result of your work injury, we will send you additional information about available vocational rehabilitation services.

However, if you have returned to work and are earning wages comparable to those you were earning at the time of your injury, you may not be eligible for this assistance.

1. Are you currently working? Yes No
If yes, please answer numbers 2 and 3.
If no, proceed to number 4.
2. Are you working full time or part-time? (Check one)
3. Are you working for the employer where you were injured, or
 new employer? (Check one)

a) What is your present salary?

\$ _____ hourly \$ _____ weekly

(OVER)

b) What was your salary when you were injured?

\$_____ hourly \$_____ weekly

4. Are you able to work? Yes No
If no, please explain:

5. Do you have work restrictions as a result of your work injury? Yes No
If yes, please explain:

6. Have you been contacted about vocational rehabilitation services to assist you in returning to work? Yes No

If yes, please provide counselor name, city, and agency:

7. Do you need help in finding a suitable job? Yes No

Thank you for your participation in this survey. Please return your completed questionnaire to:

Worker's Compensation Division
Rehabilitation Unit
PO Box 7901
Madison WI 53707-7901