Farah Joseph, MD, CCFP

PRE-WORKSAFE VISIT QUESTIONNAIRE

First Name: ____________________

Last Name: ____________________

Date of the Injury (MM/DD/YYYY)**:** ____________________

Have you missed work?
□ Yes
□ No

If you have missed work, what was your last day of work (MM/DD/YYYY)? ____________________

Employer/Company Name: ____

Employer's Address: ____

Employer's Phone Number: ____________________

What is your position or job title with the employer? ____

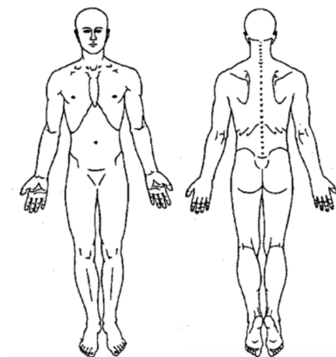
Briefly describe how you were injured:

____

____

____

Body part(s) injured (check all that apply)**:**
□ Head
□ Neck
□ Upper back
□ Lower back
□ Chest
□ Abdomen
□ Right arm
□ Left arm
□ Right leg
□ Left leg



WBC Claim Number: ____________________