Wayerski WZ Zmolek
INJURY LAW FIRM

Personal Injury  Workers' Compensation  Social Security Disability/SSI

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## SOCIAL SECURITY DISABILITY

DATE:_____

Name: _____ (Age) Birthdate: (_____)_____

Address: _____ Date of Injury: _____

City: _____ State: _____ Zip: _____ Claim No.: _____

Phone: (home)_____ (work)_____ (message)_____

Social Security #: _____ Spouse's Name_____ Children's ages:_____

Who referred you to our office?_____

Where did you last work?_____

Why did you stop working? _____

_____

When did you apply for Social Security Disability? _____

Indicate last status of claim: Date 1st application denied: _____

Date request for reconsideration filed: _____ Date reconsideration denied: _____

Date request for hearing filed: _____ Date hearing scheduled: _____

Judge assigned: _____ Who are your doctors: _____

_____

What treatment have you received: _____

_____

Highest grade completed: _____ Job held as of last date worked: _____

Wage of last job: _____ Jobs held 15 years prior to disability: _____

_____

Do you have a current workers' compensation claim? Claim No.:_____

Status (time loss rate): _____

Are you represented in that case? (Attorney): _____

Any prior industrial injuries? (Claim numbers): _____

Have you drawn public assistance or unemployment since you stopped working? (Details): _____

_____

Name of DSHS caseworker/telephone number: _____

Have you applied for Social Security Disability before (when; result)? _____

_____

Have you been represented by other attorneys in this claim (who)? _____

_____

Other information which would assist us in evaluating your claim: _____

_____

_____

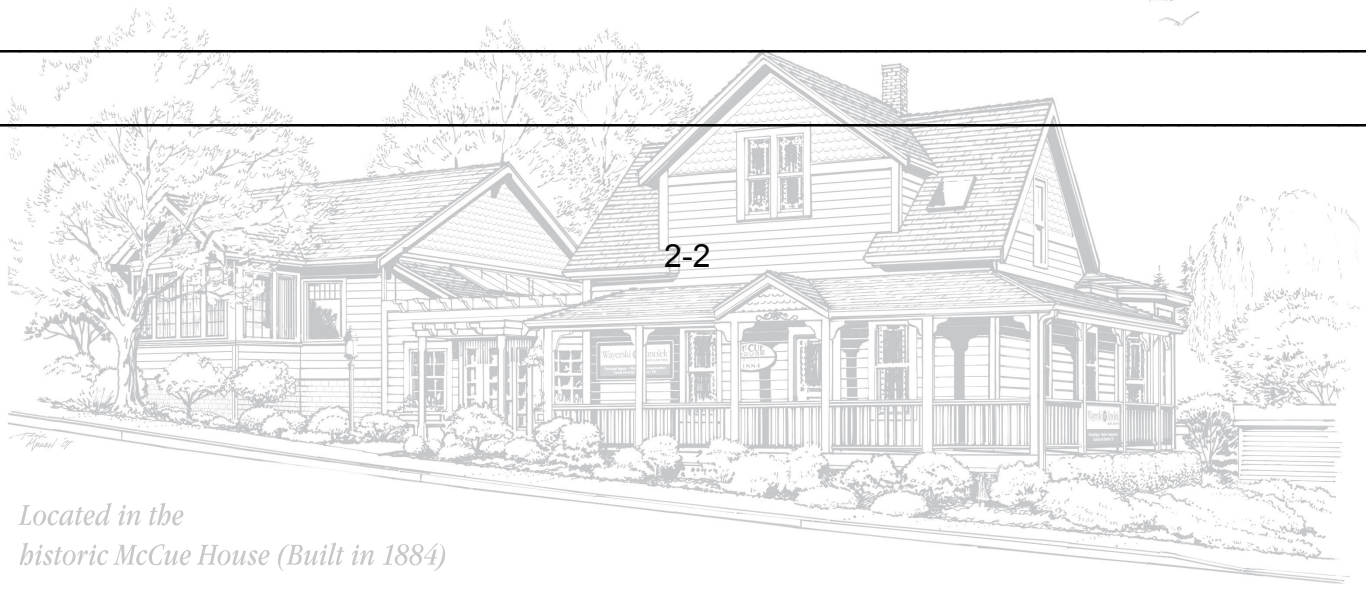
_____

_____

_____

_____





*Located in the historic McCue House (Built in 1884)*