John Parkerson, MD, MS, FACOEM
Telephone: 410-366-3627

EVALUATION REQUEST: SUBSEQUENT INJURY FUND CLAIM

Please complete and return by Email or Facsimile: johnparkersonmd@comcast.net or 410-366-1183

DATE ___ /____ / 2013

Submitted by _____ Phone/Email _____

Claimant Name _____ Employer _____

Workers' Compensation Claim Date _____/_____/_____ WC Carrier _____

Defense Attorney Name and Contact Information (Email/Phone)

_____

WORKERS' COMPENSATION CLAIM: BODY PARTS/CONDITIONS FOR RATING

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

PRE-WORK ACCIDENT/ILLNESS CLAIM: BODY PARTS/CONDITIONS FOR RATING

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

POST-WORK ACCIDENT/ILLNESS CLAIM: BODY PARTS/CONDITIONS FOR RATING

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

PRIOR PPD AWARDS

	CLAIM DATE	PARTS	Claim #, PPD %, WCC Award Date
1.	___/___/___	_____	_____
2.	___/___/___	_____	_____
3.	___/___/___	_____	_____

Please use additional pages as needed for more claims and other issues to be addressed.