LAW OFFICES OF
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CLIENT INTERVIEW FORM

SEAMEN

Interview Date:_____ Interviewed By:_____

Please fill out the following form to the best of your ability.

YOUR INFORMATION

First Name:_____ MI:_____ Last Name:_____

Address: _____

City: _____ State: _____ Zip:_____

Date of Birth:_____ SSN: _____

Marital Status: ❑ Married ❑ Single

Email Address:_____ Phone (home):_____

Phone (work): _____ Phone (cell): _____

Alternative Contact Info

Name:_____ Relationship:_____

Phone Number:_____

Union Information

Union Affiliation: _____ Registration #: _____

Book Status:_____ Dates: _____

REFERRAL SOURCE INFORMATION

How did you find us?

❑ Website
❑ Internet Search
❑ Yellow Pages
❑ Seamen Injury Hotline
❑ Friend or Relative (see below)
❑ Another Lawyer (see below)
❑ Doctor or Medical Provider (see below)
❑ Other:

Please provide the following information about who referred you to us so we may thank them for their kind recommendation.

First Name:_____ Last Name:_____

Email Address:_____ Phone Number:_____

INSURANCE COVERAGE

Maintenance & Cure

Primary Payer: _____ Secondary Payer: _____

Prescription Plan: _____

Medicare (if eligible)

HIC No.:_____

Has Medicare paid accident/injury-related bills? ❑ Yes ❑ No

Other Medical Insurance (i.e. union or employer-paid plan).
Please list all below.

INJURY REPORTING TO YOUR EMPLOYER / VESSEL OWNER

Date of Injury (or last day worked if continuous trauma injury): _____

Was the injury / accident reported? ❑ Yes (see below) ❑ No

How did you report the injury / accident? ❑ Written ❑ Oral

To Whom?: _____

When was the injury / accident reported?: _____

Do you have a copy of the injury / accident report? ❑ Yes ❑ No

Was a doctor's slip obtained? ❑ Yes (see below) ❑ No

Do you have a copy of the doctor's slip? ❑ Yes ❑ No

When did you stop work?:_____

When did your base pay stop?:_____

When did your overtime pay stop?: _____

EMPLOYER / VESSEL OWNER INFORMATION

Employer on date of injury: _____

Vessel Information

Vessel Owner (if different from employer): _____

Vessel Name: _____ Official Number: _____

Adjuster / Claims Representative (for employer)

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____ Email: _____

Adjuster / Claims Representative (for vessel owner)

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____ Email: _____

YOUR EMPLOYEMENT

Employment on date of injury: _____

Date Joined: _____

Job Title: _____

Anticipated Duration of Job: _____ Date Discharged: _____

Steady? ❑ Yes (see below) ❑ No

How long?: _____

Rotation: _____

YOUR EMPLOYEMENT *(continued)*

MARAD, Public Vessel, Government Contract? ❑ Yes (see below) ❑ No

Claim Date: _____

Statute of Limitations: _____

Pay Rate

Base Pay Per Month: _____

Base & Overtime Per Month: _____

Vacation / Supplemental Per Month: _____

Money Purchase Plan: _____

Other Pay: _____

ABOUT THE INJURY / ACCIDENT

Facts about your injury / accident:

ABOUT THE INJURY / ACCIDENT *(continued)*

Facts about your injury / accident *(continued)*

Theory of Liability: Negligence

ABOUT THE INJURY / ACCIDENT *(continued)*

Theory of Liability: Unseaworthiness

Nature of Injury
(list all injuries, body parts affected and surgeries performed and/or recommended)

ABOUT THE INJURY / ACCIDENT *(continued)*

Medical Care
(list each health care provider in the order seen and describe the general nature of treatment. Identify those providers with whom you are still seeking treatment)

PERIOD(S) OF DISABILITY & RETURN TO WORK

Temporary Total Dates: _____

Temporary Partial* Dates: _____
**Working with doctor's restrictions & with actual loss of earnings as a result.*

Permanent & Stationary Date: _____

Permanent Work Restrictions, if any: _____

_____

Fit for Duty Date: _____

Return to Work Date(s): _____

WITNESS INFORMATION

If needed, additional Witness sheets can be downloaded: www.NaylorLaw.com/Resource/Forms

Witness #1

First Name: _____ Last Name: _____

Address: _____

Phone (home): _____ Phone (cell): _____

Email Address: _____

Can Testify To/About: _____

Witness #2

First Name: _____ Last Name: _____

Address: _____

Phone (home): _____ Phone (cell): _____

Email Address: _____

Can Testify To/About: _____

Witness #3

First Name: _____ Last Name: _____

Address: _____

Phone (home): _____ Phone (cell): _____

Email Address: _____

Can Testify To/About: _____

Witness #4

First Name: _____ Last Name: _____

Address: _____

Phone (home): _____ Phone (cell): _____

Email Address: _____

Can Testify To/About: _____

PRE INJURY / ACCIDENT INFORMATION

Factors affecting pre-injury / accident earning capacity

Any change of employment/job in the two years before, or any time after, the injury / accident?
❑ Yes (see below) ❑ No

Please provide information about your change of employment / job

Any unusual time off work in the two years before, or any time after, the injury / accident?
❑ Yes (see below) ❑ No

Please provide information about your time of work

Please provide information about any *other* factors affecting your pre-injury / accident earning capacity.

PRE INJURY/ACCIENT INFORMATION (continued)

PRIOR INJURIES
(list nature of injury, health care providers, surgeries, lost time from work, amount of settlement/judgment and attorney)

Work Related

Non-Work Related

PRE INJURY/ACCIENT INFORMATION (continued)

Pre-Existing Conditions
(other than injuries listed above, including all chronic or serious physical or mental conditions. Please include nature of condition, health care providers surgeries and lost time from work.)

POST INJURY / ACCIDENT INFORMATION

Current Health Issues

POST INJURY / ACCIDENT INCOME

Unearned Wages

For what period?: _____

Amount: _____

Maintenance

For what period?: _____

Daily Rate: _____

Workers Compensation

For what period?: _____

Compensation Rate: _____

State Disability

For what period?: _____

Compensation Rate: _____

Private Disability

Provider: _____

For what period?: _____

Compensation Rate: _____