INFORMATION FORM
FOR
APPRAISAL OF FINANCIAL LOSS DUE TO INJURY TO A MAN

TO BE COMPLETED BY ATTORNEY OR ATTORNEY'S STAFF

NAME OF INJURED: _____
Telephone Number: _____
Best Time to Call: _____

Attorney for Plaintiff: _____

Address: _____

Phone Number: _____ FAX Number: _____

Paralegal/Secretary: _____

Attorney for Defendant: _____

Address: _____

Phone Number: _____ FAX Number: _____

Paralegal/Secretary: _____

Court: _____ Location: _____

Estimated Trial Date: _____

Which state's statute applies? _____
(NOTE: If other than SC, NC, GA, please provide applicable life expectancy table.)

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I. RELEVANT DATES

A. Injured Man:
Date of Birth: _____

Date of Injury: _____

Date of Beginning of Earnings Impairment _____

I. **RELEVANT DATES** (continued)

B. Family Members:

	NAME	BIRTH DATE
Spouse	_____	_____
Children	_____	_____
	_____	_____

II. **HEALTH**

A. Injured man's health condition BEFORE-INJURY:
(Check One)

1. Excellent _____
2. Good _____
3. Fair _____
4. Other (specify) _____

B. Health condition of family members:

	NAME	CONDITION
Spouse	_____	_____
Children	_____	_____
	_____	_____
	_____	_____

C. List before-injury health problems/conditions of the injured man:

_____

D. Describe the man's injuries: _____

E. BEFORE-INJURY, is there any reason to believe that, for reasons of health or habit, the injured man had less than a normal:

1. Work-Life Expectancy? _____
2. Life Expectancy? _____

II. HEALTH (continued)

F. During the five (5) years BEFORE-INJURY, list the average number of work days per year spent NOT at work:

		DUE TO:	DID PAY CONTINUE? (YES)	(NO)
1.	Sickness	_____	_____	_____
2.	Hospitalizations	_____	_____	_____
3.	Vacation	_____	_____	_____
4.	Temporary Layoffs	_____	_____	_____
5.	Job Seeking	_____	_____	_____
6.	Other (specify)	_____	_____	_____

III. EDUCATION OF THE INJURED MAN

Name of High School: _____
Location: _____
Years Attended: _____ Diploma or GED: _____

Name of College: _____
Location: _____
Years Attended: _____ # Hours Completed: _____ Major: _____
Graduate?: _____ When?: _____ Degree: _____

Name of Technical School: _____
Location: _____
Years Attended: _____ # Hours Completed: _____ Field: _____
Graduate?: _____ When?: _____ Degree/certificate: _____

Other training: _____

IV. EMPLOYMENT HISTORY

A. Employment at Time of Injury:
1. Employer: _____
   Address: _____
   Telephone: _____
2. Position/Job Title: _____
3. Job Description: _____
4. Date of Beginning Employment (above employer): _____
5. Average Hours Worked Per Week:
   (a) Regular Hours: _____
   (b) Overtime Hours: _____

IV. EMPLOYMENT HISTORY (continued)

6. Average Weeks per Year Worked: _____
(include paid vacations)

7. At what age did the injured man plan to retire? _____

B. Previous Employment:

	Employer Name	Effective Dates (From - - To -)	Position/Job Title
1.			
2.			
3.			
4.			

V. SALARY OR WAGE RATES

A. BEFORE-INJURY:

List salary or wage rates over the 5 years immediately before-injury:

Effective Dates: month	day	year	Specify Rate per: HOUR/WEEK/MONTH/YEAR
		19	
		19	
		19	
		20	
		20	

B. Amount, if any, paid in Union Dues (per week, month, year): _____

C. Regarding employment at time of injury: _____

If the man had not been injured and his work had remained satisfactory, what pay raises would he have received?

Effective Dates: month	day	year	Specify Rate per: HOUR/WEEK/MONTH/YEAR
		19	
		19	
		19	
		20	
		20	

(note: request this information in a statement from the employer)

VI. EMPLOYMENT AFTER-INJURY

A. Did the injured man return to work AFTER-INJURY? YES: ____ NO: _____

B. If YES:

1. Employer: _____

   Address: _____

   Telephone: _____

2. Position/Job Title: _____

3. Job Description: _____

4. Date Injured Man returned to work: _____

5. Average Hours Worked Per Week:

   (a) Regular Hours: _____

   (b) Overtime Hours: _____

6. Average Weeks per Year Worked: _____
   (include paid vacations)

7. Starting salary or wage rate: _____
   (specify hourly, weekly, annual)

8. List subsequent changes in salary or wage rate:

Effective Dates:			Specify Rate per:
month	day	year	HOUR/WEEK/MONTH/YEAR
_____	_____	19	_____
_____	_____	19	_____
_____	_____	19	_____
_____	_____	20	_____
_____	_____	20	_____

9. Is the injured man still employed? YES: _____ NO: _____
   If no, when did the injured man stop work? _____

VII. EMPLOYEE BENEFITS

A. Health Insurance Provided by Employer

1. Was the injured man covered? _____
2. Were the dependents covered? _____
3. At the time of injury, how much, if any, did the injured man pay for health insurance coverage for:

	$ Amount Paid	Specify Per Pay Period Month/Year
a. Himself	_____	_____
b. Dependents	_____	_____

4. Has coverage stopped:
   a. For the injured man? Yes _____ No _____
   b. For the dependents? Yes _____ No _____

5. If coverage has stopped, list effective date:
   a. For the injured man: _____
   b. For the dependents: _____
6. Has the injured man purchased new health insurance?
   YES: _____ NO: _____

7. If yes:

Effective Date Coverage Began	$ Amount Paid	Specify per Pay Period Month/Year
_____	_____	_____

8. Have the dependents purchased new health insurance?
   YES: _____ NO: _____

9. If yes:

Effective Date Coverage Began	$ Amount Paid	Specify per Pay Period Month/Year
_____	_____	_____

VII. **EMPLOYEE BENEFITS** (continued)

B. Dental Insurance Provided by Employer

1. Was the injured man covered? _____
2. Were the dependents covered? _____
3. At the time of injury, how much, if any, did the injured man pay for dental insurance coverage for:

	$ Amount Paid	Specify Per Pay Period Month/Year
a. Himself	_____	_____
b. Dependents	_____	_____

4. Has coverage stopped:
   a. For the injured man? Yes _____ No _____
   b. For the dependents? Yes _____ No _____

5. If coverage has stopped, list effective date:
   a. For the injured man: _____
   b. For the dependents: _____

6. Has the injured man purchased new dental insurance?
   YES: _____ NO: _____

7. If yes:

Effective Date Coverage Began	$ Amount Paid	Specify per Pay Period Month/Year
_____	_____	_____

8. Have the dependents purchased new dental insurance?
   YES: _____ NO: _____

9. If yes:

Effective Date Coverage Began	$ Amount Paid	Specify per Pay Period Month/Year
_____	_____	_____

VII. **EMPLOYEE BENEFITS** (continued)

C. Life Insurance Provided by Employer

1. Was the injured man provided life insurance coverage by his employer? YES: _____ NO: _____

2. Face value of life insurance coverage at time of injury?
_____

3. At the time of injury, how much, if any, did the injured man pay for life insurance coverage:

	$ Amount Paid	Specify Per Pay Period Month/Year
a. Himself	_____	_____

4. Has coverage stopped? YES: _____ NO: _____
If yes, when did coverage stop? _____

D. Retirement/Pension Plan Benefits

1. Did the injured man participate in a retirement/pension plan?
YES: _____ NO: _____

2. How many years, months, and days had the injured man participated in the plan at the time of injury? _____

E. Savings/401(k) Plan

1. Did the injured man participate in a company-sponsored savings/401(k) plan? YES: _____ NO: _____

2. How many years had the injured man participated in the plan at the time of injury? _____

3. What percentage of the injured man's gross annual income was contributed to the plan?
   a. By the man? _____%
   b. By the employer? _____%

F. Other Employee Benefits (list and describe)
_____

VIII. ADDITIONAL EMPLOYMENT HISTORY

A. Was the injured man working for any additional employers?
Yes _____ No _____
(If yes, complete the following sections; if no, skip to item IX)

B. Additional employer:
1. Complete name of additional employer: _____
2. Address of additional employer: _____
3. Phone number of additional employer: _____

C. Salary or wage rate from the additional employment
(indicate whether hourly, biweekly, monthly, or annual): _____

D. Date began employment with this employer: _____

E. Was the injured man covered by any benefits with this employer?
Yes _____ No _____

If yes, specify: _____

F. Is the injured man still working for this employer?
Yes _____ No _____

If no, when did the injured man stop work? _____

IX. VOCATIONAL ASSESSMENT / PSYCHOLOGICAL EVALUATION

A. Has a vocational assessment/psychological evaluation been performed to determine the injured man's before-and after-injury earning capacities?
Yes _____ No _____

B. If yes, please indicate the following regarding the assessor/evaluator:
1. Name: _____
2. Title(s): _____
3. Address: _____
4. Telephone: _____

X. FUTURE MEDICAL CARE

A. Has a life care plan been prepared? Yes _____ No _____

B. If yes, indicate the following regarding the assessor/evaluator:

1. Name: _____
2. Title(s): _____
3. Address: _____
4. Telephone: _____

C. If no, and if, because of injury, the man requires future medical care, please specify below: (e.g., physical therapy sessions, annual physician visits, attendant care, medications, etc.).

	MED. CARE ITEM	HOW OFTEN	CURRENT COST	HOW LONG NEEDED	PROVIDER
1.					
2.					
3.					
4.					
5.					

(Note: for each item, obtain a statement from physician and/or other expert prescribing the various care items.)

XI. PERSONAL/FAMILY SERVICES (Chores)

This excludes employment, recreational, leisure, and family time.

A. BEFORE-INJURY

Types of Personal/Family Services Performed by Man:

1. Inside Chores

	YES	NO		YES	NO
Cook Meals			Canning/Freezing		
Baking			Vacuum		
Wash Dishes			Dusting		
Sweep/Mop/Wax			Clean Bathrooms		
Wash Windows			Take out Trash		
Laundry			Other		
Ironing			Other		

XI. PERSONAL/FAMILY SERVICES (Chores) (continued)

	YES	NO		YES	NO
Mow Lawn			Weeding		
Rake Leaves			Pump Gas/Check Tire Pressure		
Trim Shrubs			Grocery Shopping		
Wash/Wax Car			Clothes Shopping for Family		
Paint House: Inside			Tend Vegetable Garden		
Outside			Auto Repairs		
Clean Gutters			Home Repairs		
Pet Care			Carpentry Work		
Other (specify): _____					

	YES	NO		YES	NO
Car Pool			Chauffeur		
Bathe Children			Dress Children		
Feed Infants			Change Diapers		
Health Care			Help w/ Homework		
Baby-sitting					

B. BEFORE-INJURY

Average Number of Hours Per Day:

(Note: The average man performs approximately 10 hours per week of personal/family services.)

Monday-Friday	(5 days)	X	(hours/day)	=		hours/week
Saturday	(1 day)	X	(hours/day)	=		hours/week
Sunday	(1 day)	X	(hours/day)	=		hours/week
			Average Hours Per Week:			

XI. PERSONAL/FAMILY SERVICES (Chores) (continued)

C. AFTER-INJURY

1. Immediately after injury: Were there any times when the injured man could not perform any chores around the home:

Yes _____ No _____

If Yes, specify inclusive dates: _____

2. Currently able to perform: Check the appropriate line which best describes the injured man's ability to perform personal/family services now:

	Able to Perform Without Pain	**Can Perform at But With Difficulty**	**Unable to At Anytime**
1. Inside Chores			
Cook Meals			
Baking			
Canning/Freezing			
Wash Dishes			
Sweep/Mop/Wax			
Wash Windows			
Laundry			
Ironing			
Vacuum			
Dusting			
Clean Bathrooms			
Take out Trash			
Other			
Other			

	Able to Perform Without Pain	**Can Perform at But With Difficulty**	**Unable to At Anytime**
2. Outside Chores			
Mow Lawn			
Rake Leaves			
Trim Shrubs			
Wash/Wax Car			
Paint House:			
Inside			
Outside			

XI. PERSONAL/FAMILY SERVICES (Chores) (continued)

2. Outside Chores (continued)	Able to Perform Without Pain	Can Perform at Times But With Difficulty	Unable to Perform At Anytime
Clean Gutters			
Weeding			
Pump Gas/Check Tire Pressure			
Grocery Shopping			
Clothes Shopping for Family			
Tend Vegetable Garden			
Home Repairs			
Auto Repairs			
Pet Care			
Other (specify)			

3. Child Care	Able to Perform Without Pain	Can Perform at Times But With Difficulty	Unable to Perform At Anytime
Car Pool			
Bathe Infants			
Feed Infants			
Health Care			
Baby-sitting			
Chauffeur			
Dress Children			
Change Diapers			
Help w/ Homework			

D. At Present: Average Number of Hours Per Day that the injured man can perform personal/family chores:

Monday-Friday	(5 days)	X	(hours/day)	=		hours/week
Saturday	(1 day)	X	(hours/day)	=		hours/week
Sunday	(1 day)	X	(hours/day)	=		hours/week
			Average Hours Per Week:			

XII. SUMMARY OF SUPPORTING DOCUMENTATION REQUIRED

A. Complaint and Answer
B. Depositions of:
    1. Injured Man
    2. Injured Man's Employer and/or Personnel Mgr.
    3. Other Experts (Vocational/Medical, etc.)
C. Vocational Assessment
D. Life Care Plan (if applicable)
E. Future Medical Care Statements
F. Complete Income Tax Returns and W-2 Wage and Tax Statements for the past 5 years (legible copies, do not send originals)
G. Payroll Records
H. Most Recent Pay Stub
I. Benefit Booklets (containing formulas)
    1. Health Insurance
    2. Dental Insurance
    3. Life Insurance
    4. Retirement/Pension Plan
    5. Savings/401(k) Plan
    6. Annual Benefits Statements
    7. Union Agreements (if applicable)