

**INFORMATION FORM
FOR
APPRAISAL OF FINANCIAL LOSS DUE TO INJURY TO A WOMAN**

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.)

I. RELEVANT DATES

A. Injured Woman:

Date of Birth: _____

Date of Injury: _____

Date of Beginning of Earnings Impairment: _____

I. **RELEVANT DATES** (continued)

B. Family Members:

	<u>NAME</u>	<u>BIRTH DATE</u>
Spouse	_____	_____
Children	_____	_____
	_____	_____
	_____	_____

II. **HEALTH**

A. Injured woman's health condition BEFORE-INJURY:

(Check One)

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

B. Health condition of family members:

	<u>NAME</u>	<u>CONDITION</u>
Spouse	_____	_____
Children	_____	_____
	_____	_____
	_____	_____

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

D. Describe the woman's injuries: _____

E. BEFORE-INJURY, is there any reason to believe that, for reasons of health or habit, the injured woman 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 WOMAN

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 woman 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			Specify Rate per:
<u>month</u>	<u>day</u>	<u>year</u>	<u>HOUR/WEEK/MONTH/YEAR</u>
_____	_____	19	_____
_____	_____	19	_____
_____	_____	20	_____
_____	_____	20	_____
_____	_____	20	_____

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

C. Regarding employment at time of injury:

If the woman had not been injured and her work had remained satisfactory, what pay raises would she have received?

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

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

VI. EMPLOYMENT AFTER-INJURY

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

B. If YES:

1. Employer: _____

Address: _____

Telephone: _____

2. Position/Job Title: _____

3. Job Description: _____

4. Date Injured Woman 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:
<u>month</u>	<u>day</u>	<u>year</u>	<u>HOUR/WEEK/MONTH/YEAR</u>
_____	_____	19	_____
_____	_____	19	_____
_____	_____	20	_____
_____	_____	20	_____
_____	_____	20	_____

9. Is the injured woman still employed? YES: ____ NO: ____

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

VII. EMPLOYEE BENEFITS

A. Health Insurance Provided by Employer

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

	<u>\$ Amount Paid</u>	<u>Specify per Pay Period Month/Year</u>
a. Herself	_____	_____
b. Dependents	_____	_____

- 4. Has coverage stopped:
 - a. For the injured woman? Yes _____ No _____
 - b. For the dependents? Yes _____ No _____
- 5. If coverage has stopped, list effective date: _____
 - a. For the injured woman: _____
 - b. For the dependents: _____

- 6. Has the injured woman purchased new health insurance?
YES: _____ NO: _____

- 7. If yes:

<u>Effective Date</u>	<u>\$ Amount Paid</u>	<u>Specify per Pay Period</u>
<u>Coverage Began</u>		<u>Month/Year</u>

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

- 9. If yes:

<u>Effective Date</u>	<u>\$ Amount Paid</u>	<u>Specify per Pay Period</u>
<u>Coverage Began</u>		<u>Month/Year</u>

VII. EMPLOYEE BENEFITS (continued)

B. Dental Insurance Provided by Employer

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

	<u>\$ Amount Paid</u>	<u>Specify per Pay Period Month/Year</u>
a. Herself	_____	_____
b. Dependents	_____	_____

- 4. Has coverage stopped:
 - a. For the injured woman? Yes _____ No _____
 - b. For the dependents? Yes _____ No _____
- 5. If coverage has stopped, list effective date:
 - a. For the injured woman: _____
 - b. For the dependents: _____

6. Has the injured woman purchased new health insurance?
YES: _____ NO: _____

7. If yes:

<u>Effective Date Coverage Began</u>	<u>\$ Amount Paid</u>	<u>Specify per Pay Period Month/Year</u>
_____	_____	_____

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

9. If yes:

<u>Effective Date Coverage Began</u>	<u>\$ Amount Paid</u>	<u>Specify per Pay Period Month/Year</u>
_____	_____	_____

VII. EMPLOYEE BENEFITS (continued)

C. Life Insurance Provided by Employer

1. Was the injured woman provided life insurance coverage by her 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 woman pay for life insurance coverage:

	<u>\$ Amount Paid</u>	<u>Specify per Pay Period Month/Year</u>
a. Herself	_____	_____

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

D. Retirement/Pension Plan Benefits

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

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

E. Savings/401(k) Plan

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

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

3. What percentage of the injured woman's gross annual income was contributed to the plan?

a. By the woman? _____ %

b. By the employer? _____ %

F. Other Employee Benefits (list and describe): _____

VIII. ADDITIONAL EMPLOYMENT HISTORY

- A. Was the injured woman 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 woman covered by any benefits with this employer?
Yes _____ No _____
If yes, specify: _____
- F. Is the injured woman still working for this employer?
Yes _____ No _____
If no, when did the injured woman stop work? _____

IX. VOCATIONAL ASSESSMENT / PSYCHOLOGICAL EVALUATION

- A. Has a vocational assessment/psychological evaluation been performed to determine the injured woman'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 woman 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 Woman:

1. **Inside Chores:**

	<u>YES</u>	<u>NO</u>		<u>YES</u>	<u>NO</u>
Cook Meals	_____	_____	Canning/Freezing	_____	_____
Baking	_____	_____	Vacuum	_____	_____
Wash Dishes	_____	_____	Dusting	_____	_____
Sweep/Mop/Wa x	_____	_____	Clean Bathrooms	_____	_____
Wash Windows	_____	_____	Take out Trash	_____	_____
Laundry	_____	_____	Sewing/Mending	_____	_____
Ironing	_____	_____	Other	_____	_____

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

2. **Outside Chores:**

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

3. **Child Care (includes children living in the household only)**

	<u>YES</u>	<u>NO</u>		<u>YES</u>	<u>NO</u>
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:)**

Notes: 1. The average woman working outside the home, with or without children, performs approximately 4 - 6 hours per day, 5 days per week (Monday-Friday), 4 - 10 hours on Saturdays, and 4 - 6 hours on Sunday, for a total of 28 - 46 hours per week.

2. The average woman who does not work outside the home, with or without children, performs approximately 4 - 10 hours per day, 5 days per week (Monday-Friday), 4 - 10 hours on Saturdays, and 4 - 6 hours on Sunday, for a total of 28 - 66 hours per week.

3. The total hours of personal/family services (chores) performed per day/per week depends on many factors including number of children.

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 woman 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 woman's ability to perform personal/family services now:

1. <u>Inside Chores</u>	Able to Perform Without Pain	Can Perform at But With Difficulty	Unable to Perform At Anytime
Cook Meals	_____	_____	_____
Baking	_____	_____	_____
Canning/Freezing	_____	_____	_____
Wash Dishes	_____	_____	_____
Sweep/Mop/Wax	_____	_____	_____
Wash Windows	_____	_____	_____
Laundry	_____	_____	_____
Ironing	_____	_____	_____
Vacuum	_____	_____	_____
Dusting	_____	_____	_____
Clean Bathrooms	_____	_____	_____
Take out Trash	_____	_____	_____
Sewing/Mending	_____	_____	_____
Other	_____	_____	_____
2. <u>Outside Chores</u>	Able to Perform Without Pain	Can Perform at Times But With Difficulty	Unable to Perform At Anytime
Mow Lawn	_____	_____	_____
Rake Leaves	_____	_____	_____
Trim Shrubs	_____	_____	_____
Wash/Wax Car	_____	_____	_____
Paint House:	_____	_____	_____
Inside	_____	_____	_____
Outside	_____	_____	_____

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

2. <u>Outside Chores</u> (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. <u>Child Care</u>	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 woman 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 Woman
 - 2. Injured Woman's Employer/Pers. 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)