Name _____ Job Title FIREFIGHTER or DISPATCHER

Social Security Number _____ Department KENDALL FIRE DEPARTMENT

Date Start to Work _____/_____/_____.
mo. day yr.

Mailing Address_____ Phone _____

COMPENSATION STATEMENT

PREVIOUS WORKERS' COMPENSATION CLAIMS:

Have you ever missed work due to a job related injury or illness.
Yes_____ No_____.
If yes, please explain the nature of the injury or illness and state how many days of work were missed during each of the last 5 years due to the job related injury or illness.

STATE	NAME OF EMPLOYER	DESCRIPTION OF INJURY	DATE OF INJURY	NAME OF DOCTOR	TYPE OF TREATMENT	#OF DAYS MISSED WORK

Current status of problem (s):

THIS AFFIRMATION MUST BE COMPLETED

I affirm that the statements made on this self-assessment health form (including any attached papers) are true under the penalties of perjury.

_____ _____
SIGNATURE DATE

06/94