STATE OF NEW JERSEY – DEPARTMENT OF LABOR AND WORKFORCE DEVELOPMENT
DIVISION OF TEMPORARY DISABILITY INSURANCE

PART A | **INFORMATION TO BE COMPLETED BY THE CLAIMANT – Print or Type** WDS-1(R-12-15)

1. **Name**: Last	First	Middle	2. **Birth Date**	3. **Social Security Number**

4. **Home Address – required** (Street, Apt #, City, State, Zip Code)

5. County

6. **Mailing Address – if different** (Street, Apt #, City, State, Zip Code)

7. Male ☐ Female ☐

8. Occupation

9. Are you a citizen of the United States? Yes ☐ No ☐

If **NO**, answer #10 & 11 and give country of origin: _____

10. Alien Reg. No.

11. Work Authorization

From _____ To _____

	Month	Day	Year
12a. What was the last day that you actually worked before your disability began?			
12b. Reason for separation: ☐ Illness/Accident/Maternity ☐ Terminated ☐ Quit			
13. What was the **first day you were unable to work** due to present disability: (Include Saturday, Sunday, or Holiday) Do not list future dates			
14. If you have **recovered or returned to work from this disability, list date:** (Do not use dates in the future)			

15. Date(s) of emergency room care: _____ (Month/Day/Year) or hospitalization: From _____ (Month/Day/Year) To _____ (Month/Day/Year)

16. **Describe your disability (How, when, where it happened)** _____

_____

17. Was this injury/illness caused by your job? Yes ☐ or No ☐ (This question must be answered.)
If Yes, date of work related injury/illness: _____
Was your employer notified that your injury/illness was a result of a work-related accident? Yes ☐ or No ☐

18. Identify the physician or hospital treating you for this disability: Name: _____

Address: _____ Telephone: (____) _____

Employment Information – Beginning with your last employer, list all employment (both full and part-time) in the past 18 months. If you had more than 2 employers, list the remaining employers on the reverse side of this form in the space provided.

19a. Name and address of your most recent employer:

_____

_____
(Street) (City) (State) (Zip)

Period of employment: From _____ (month/day/year) To _____ (month/day/year)

Telephone: _____ Work Location _____ (City) (State)

Occupation: _____ Full time ☐ Part time ☐ Union _____ Division _____

Check the days of the week you normally work. SUN ☐ MON ☐ TUE ☐ WED ☐ THUR ☐ FRI ☐ SAT ☐

19b. Name and address:

_____

_____
(Street) (City) (State) (Zip)

Period of employment: From _____ (month/day/year) To _____ (month/day/year)

Telephone: _____ Work Location _____ (City) (State)

Occupation: _____ Full time ☐ Part time ☐ Union _____ Division _____

Check the days of the week you normally work. SUN ☐ MON ☐ TUE ☐ WED ☐ THUR ☐ FRI ☐ SAT ☐