



**THIRD PARTY NOTICE – SLIP  
AND FALL QUESTIONNAIRE**  
LEGAL DIVISION  
SFN 54052 (12/2016)

1600 E Century Ave, Ste 1  
PO Box 5585  
Bismarck ND 58506-5585  
**Telephone 800-777-5033**  
Toll Free Fax 888-786-8695  
TTY (hearing impaired) 800-366-6888  
Fraud and Safety Hotline 800-243-3331  
www.workforcesafety.com

| <b>SECTION 1 – Injured worker information</b>   |                               |             |                |
|---|-------------------------------|-------------|----------------|
| Claim number  | Injured worker's (First name) | (Last name) | Date of injury |
| <b>SECTION 2 – Questions</b>  |                               |             |                |
| Describe how and when the injury occurred (Example: time of day, etc). Provide the address, city, county, and state where the injury occurred.                              |                               |             |                |
| Describe the location of your fall (Example: sidewalk, street, or parking lot).   |                               |             |                |
| Describe the weather conditions and the condition of the property where you fell (Example: had the property been maintained, shoveled, salted, or was the sidewalk uneven). |                               |             |                |
| Who is responsible for maintaining and repairing the property where you fell? If known, provide the name, address, and telephone number of the property owner.              |                               |             |                |
| Describe the footwear you were wearing at the time of your injury.  |                               |             |                |
| Describe what you were doing immediately before your injury.  |                               |             |                |
| List all witnesses and anyone who has information about your injury. Provide names, addresses, and telephone numbers.   |                               |             |                |

Form is continued on next page. Submit all pages to WSI.

**THIRD PARTY NOTICE – SLIP AND FALL QUESTIONNAIRE (cont'd)**

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|              |                               |             |
|--------------|-------------------------------|-------------|
| Claim number | Injured worker's (First name) | (Last name) |
|--------------|-------------------------------|-------------|

|  |                              |
|--|------------------------------|
| Do you believe someone else (an individual or business other than your employer) was at fault or caused your injury?<br><input type="checkbox"/> Yes <input type="checkbox"/> No                               |                              |
| If yes, explain why  |                              |
| List the names, addresses, and telephone numbers of the individuals or businesses who may be responsible for your injury.  |                              |
| Have you been in contact with any individual, business, or an insurance company about the incident?<br><input type="checkbox"/> Yes <input type="checkbox"/> No  |                              |
| If yes, list the name, address, company, telephone number, and email address.  |                              |
| If known, provide the policy number and claim number.  |                              |
| Have you received money from an individual, business, or an insurance company in connection with your injury?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> In progress |                              |
| If yes, provide the amount.  | Date the money was received. |
| Do you intend to pursue legal action against anyone because of your injury?<br><input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Undecided                                     |                              |
| Have you hired an attorney because of your injury?<br><input type="checkbox"/> Yes <input type="checkbox"/> No   |                              |
| If yes, provide their name, address, telephone number, and email address.  |                              |

**SECTION 3 – Lien notice/signature****Lien notice**

WSI has a lien in the full amount it has paid in all benefits for this claim. This lien attaches to all claims, demands, settlement proceeds, judgment awards, or insurance payable by reason of a legal liability of a third person. If you receive any money in regard to this claim from a third person or their insurance company, and WSI does not receive payment of its lien within 30 days of their payment to you, WSI may sue you and/or your personal injury attorney for the full amount of the lien. No release of liability or satisfaction of any judgment, claim or demand is valid or effective against WSI's lien.

**Signature**

By signing this document, I acknowledge that the information provided here is true and correct to the best of my knowledge. I understand that I must notify WSI at the time I begin to pursue settlement negotiations or seek the assistance of an attorney in this matter.

|                                   |             |
|-----------------------------------|-------------|
| <b>Injured worker's signature</b> | <b>Date</b> |
|-----------------------------------|-------------|