877.391.2255 | Fax 866.260.8572 | Email completed form to:
SchaumburgILReferrals@genexservices.com
or use the Submit button at the end of this form.

Alternative Transitional Duty Referral Form

Our intake specialist will contact you if additional information is needed. Please submit any physical restrictions received from medical provider.

Injured Worker Information

Client (Associate) First Name: Last Name:

Last 4 of SSN: Date of Birth: Age: Gender:

Driver's License #: State Issued:

Physical Address:

City: State: Zip:

Non-Work Phone: Cell Phone: Email:

Occupation:

Date of Injury: State Jurisdiction:

Attorney (If Involved):

Phone: Email:

Languages Spoken: Dominant Hand: Left Right

Date Available to Start Work at Nonprofit: Hours Worked Per Week Pre-Injury:

Average Weekly Wage: Weekly Compensation Rate:

Who Will Be Paying Injured Employee?: Employer TPA/Carrier Employer/TPA/Carrier Combined

Claim #: Type of Injury (Back, Ankle, Etc.):

Specific Medical Restrictions: Date of Restrictions:

Is a Lunch Break Required?: Yes No If yes, please indicate length:

Doctor Who Signed Release: Next Doctor's Appt:

Any documented allergies to certain environments? If so, please explain:

Any Felony Convictions?: Yes No

Computer Skills?: Basic Internet

Employer Information

Employer: **Phone:**

Address:

City: **State:** **Zip:**

Primary Contact: **Email:**

Copy: **Email:**

Copy: **Email:**

Other Contacts:

Other Contacts:

Other Contacts:

Case Manager: **Work Phone:** **Cell Phone:**

Email:

Adjuster: **Work Phone:** **Cell Phone:**

Email:

Additional Comments or Pertinent Restrictions (e.g., allergies contraindicating certain environments)

Submit

Reset