

WORKERS' COMPENSATION

To process your compensation claim we must have the following information. Please complete this form and give us any paperwork related to this injury.

Date: _____

Patient's Name: _____

Patient's Address: _____

Employer's Name: _____

Address: _____

Phone number: _____ Fax number: _____

Workers Compensation Insurance Company:

Name: _____

Address: _____

Policy #: _____ Case#: _____

Date of Injury: _____ Place of Injury: _____ (city, state)

Detailed description on how the injury occurred: _____

Are you currently working? Yes No Full Time/Part Time _____