WORKER COMPENSATION INFORMATION

Date_____

Employer

Employer Name _____
Employer Address_____
Employer Phone (_____)_____ Email _____
Injury verified by (*For office use*) _____
Contact Person_____

Worker Compensation Carrier

Worker Compensation Carrier_____
Carrier Address_____
Carrier Phone (_____)_____ Coverage Verified by_____
Adjuster's Name_____ Claim Number _____
Attorney's Name_____
Attorney's Address_____

Injury Information

Date of injury ____/_____/___ Time _____ ☐ AM ☐ PM
Place of injury_____
Was the incident reported to a supervisor? ☐ Yes ☐ No
Name of person you reported accident to _____
Describe the incident in 1-3 sentences. _____

_____

_____

Have you lost time from work? ☐ Yes ☐ No How much?_____
Were you sent to see a doctor? ☐ Yes ☐ No
Other doctors seen for this condition: Doctor's name_____
Diagnosis _____
Were X-rays taken? ☐ Yes ☐ No Other Tests? ☐ Yes ☐ No
If Yes, by whom? Please list test(s) and result(s)_____

_____

Are there problems that effect work? What?_____
Do you favor 1 side in work? ☐ Yes ☐ No If so, which side?_____
Before the injury did you do work equally to others your age? ☐ Yes ☐ No
Any previous Worker Compensation injuries? ☐ Yes ☐ No
Date(s) of previous injuries_____
Describe previous Worker Compensation injuries_____

_____

I clearly understand and agree that all services rendered to me are charged directly to me and that I am personally responsible for payment in the event that my claim for Worker Compensation benefits is denied. I understand that filing for Worker Compensation benefits does not relieve me from my responsibility for the payment of all charges.

_____ _____
Signature of Patient, Parent, Guardian or Personal Representative Date

_____ _____
Print name of Patient, Parent, Guardian or Personal Repres. Relationship to Patient