WORKERS' COMPENSATION INFORMATION SHEET

Employee Information

Employee Name: ______________________________ **Date of Birth:** __________ **Today's Date:** ___________

Injury date: __________________ **In what state did the injury occur?:** ______________________

What part of your body is injured? ____________________________________ ☐ **Right** ☐ **Left** ☐ **Both**

Have you been seen elsewhere for this injury? ____

(If yes, please complete the medical record release form.)

Employer Information

Employer name: _____________________________ **Company contact:** __________________________________

Address: ____

City: ____ **State:** _____________ **Zip:** _______________

Phone: _____________________________ **Ext.** _______ **Secure fax:** ________________________________

Treatment authorized by: _____________________________ **Title:** ________________________________

Post-Accident Drug and or Alcohol Testing Required: ☐ **Yes** ☐ **No**

Workers' Comp Billing Information

WC Insurance carrier: ____

Address: ____

City: ____ **State:** _____________ **Zip:** _______________

Phone: ______________________________________ **Secure fax:** ________________________________

Policy #: _____________________________________ **Claim #:** ___________________________________

Adjuster name: _______________________________ **Adjuster phone:** ___________________________

Internal Use Only:

Form reviewed by: ____ **Date:** _________________

Charges to be billed to: ☐ **Employer** ☐ **Work Comp Carrier** ☐ **Employee**