

WORKER'S COMPENSATION INFORMATION

Patient Name _____ DOB ____/____/____

Worker's Compensation Claim Number _____

WCB Number _____

Date of Injury and Time _____

Address where your injury occurred:

Name, address, phone number of employer:

Please describe in your own words how your injury occurred:

Where is your injury? _____

Name, address, phone number of insurance carrier:

Claim Representative Name and Phone Number:

Attorney name and phone number:
