WORKER'S COMPENSATION FORM

NOTICE: If you were injured on the job, you must **REPORT THE INJURY** to your employer. Failure to do so will result in denial of any payment. In the event that your worker's compensation insurance will not cover, you are responsible for your bill. Thank you.

NAME:____DATE OF BIRTH____________________

ADDRESS:_____________________________________CITY____________STATE_____ZIP_________

Must have street address if P.O. Box

SOCIAL SECURITY #________________________ Home Phone_________________ Work Phone________________

EMPLOYER:___________________________________ADDRESS:______________________________

Name of person you reported the injury to: ____

Is this person your supervisor? Yes / No If no, supervisor's name: ______________________________

Who referred you to our office?____

Please explain how the accident happened:____

____

____

____

Date of present injury:_________________ Time:__________________

Did you feel pain immediately at the time of the injury? YES / NO *(If no, please state when you began to have pain and where.)*____

____

Did you return to work following the injury? YES / NO

When you reported the injury to your supervisor, were you instructed to see a particular Dr.? YES / NO

How much time have you lost from work as a result of this injury? ____________________________

AGREEMENT TO PAY IN THE EVENT COMPENSATION IS DENIED:

In the event that I fail to prosecute the claim for worker's compensation for this illness or condition or it is determined that the illness or condition is not a result of a compensable worker's compensation case, I hereby agree to pay this office's usual and customary fees for services rendered to me.

Date__________________________ Signature____

PLEASE DO NOT WRITE BELOW THIS LINE

(*Verifications will be indicated on call-in sheet if patient not a walk-in.)*

This injury was verified by ________________________on _________. Time of Call: _________________

Name of supervisor or employer who verified the injury:____

Claims mailing address:______________________________________ Employer recognizes claim:

______________________________________ YES / NO