Workers Compensation Worksheet

DATE: _____

PATIENT INFORMATION

PATIENTS NAME: _____

DATE OF BIRTH: _____

SOCIAL SECURITY NUMBER: _____

EMPLOYER: _____

WORK PHONE: _____

EMPLOYER ADDRESS: _____

EMERGENCY CONTACT: _____ PHONE: _____

CLAIM INFORMATION

INDUSTRIAL CARRIER NAME: _____

INDUSTRIAL CARRIER ADDRESS: _____

CLAIM ADJUSTER'S NAME: _____

CLAIM ADJUSTER'S PHONE:_____ FAX: _____

INSUSTIAL CLAIM NUMBER: _____

DATE OF INJURY: _____

BODY PART INJURED: _____

BRIEF DESCRIPTION OF INJURY: _____

_____

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