WORKERS' COMPENSATION INTRODUCTION FORM

Today's Date: _____

Last Name:	**MI:**	**First Name:**
Date of Injury:	**Date:** **Time:**	
Name Employer at Time of Injury:		
Address of Employer:		
Job Title at Time of Injury:	**Title:**	**Length of time employed (months/yrs):**
Name of Current Employer:		

Briefly describe what happened according to your patient:

_____

_____

HAS PATIENT LOST TIME FROM WORK DUE TO THIS INJURY?
CIRCLE: YES NO

If YES, DATES: FROM _____ **TO** _____

☐ **YES,** ☐ **NO** **Has employer been notified about patient's injury?**
☐ **YES,** ☐ **NO** **Has employer notified their workers' compensation insurance carrier?**
☐ **YES,** ☐ **NO** **Has patient filled out an injured workers' claim form?**
☐ **YES,** ☐ **NO** **Does patient have an attorney this work-related injury?**
Attorney Name: _____
Address: _____
_____
Phone # _____

WORKERS' COMPENSATION INSURANCE INFORMATION

Name of Insurance Carrier:	
Address of Insurance Carrier:	
Claim Adjuster's Name/ Telephone:	**Name:** **Telephone:**
Claim Number:	