WARWICK CHIROPRACTIC AND MASSAGE

8650 Martin Way E #207, Lacey WA 98516

WORKERS' COMPENSATION / LABOR & INDUSTRIES INFORMATION

DATE_________________

FIRST NAME ____ LAST NAME ____

DATE OF INJURY _____________________________________ TIME OF INJURY ____________________ AM / PM

NAME OF EMPLOYER AT TIME OF INJURY ____

ADDRESS OF EMPLOYER AT TIME OF INJURY ____

JOB TITLE AT TIME OF INJURY _____________________________________ LENGTH OF TIME EMPLOYED _______YEARS _______MONTHS

NAME OF CURRENT EMPLOYER IF DIFFERENT THAN EMPLOYER AT TIME OF INJURY____

BRIEFLY DESCRIBE WHAT HAPPENED TO CAUSE YOUR INJURY ____

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HAVE YOU LOST TIME FROM WORK DUE TO THIS INJURY? YES / NO IF YES, DATES FROM ________________ TO _______________

YES / NO HAVE YOU NOTIFIED YOUR EMPLOYER ABOUT THE INJURY?

YES / NO HAS YOUR EMPLOYER NOTIFIED THEIR WORK COMP INSURANCE CARRIER?

YES / NO HAVE YOU FILLED OUT AN INJURED WORKERS' CLAIM FORM AT ANY OTHER HEALTHCARE FACILITY?

YES / NO DO YOU HAVE AN ATTORNEY FOR THIS INJURY? IF YES: ATTORNEY NAME _____________________________________

ATTORNEY ADDRESS ____ ATTORNEY PHONE________________________

WORKER'S COMPENSATION INSURANCE INFORMATION:

NAME OF INSURANCE CARRIER ____

ADDRESS OF INSURANCE CARRIER ____

CLAIM ADJUSTER'S NAME ____ TELEPHONE _______________________________________

CLAIM NUMBER ____

Full name____Date______________________

Signature____