Workers Compensation Form

PLEASE PRINT CLEARLY

Name: _____ Date: _____ DOB: _____

Workers Comp Information:

Employer name: _____

Employer address: _____

Employer phone: _____

Work Comp Insurance Carrier Name: _____

Claim Number: _____

Adjuster or Nurse Case Mgr Name/Number: _____

Type of Injury: _____

Date of Injury: _____

Briefly describe what happened: _____

_____

_____

Was this reported to your employer as a work-related accident? Yes____ No ____

Was a WC-1 form completed? Yes____ No ____

Do you have an attorney? Yes ____ No ____

If yes:

Attorney's name: _____

Attorney's address: _____

Attorney's phone: _____