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Workers' Compensation Information/No-Fault

Please complete all the information – this information is vital to the processing of your compensation claim

CLAIMANT: _____REFERRED BY: _____
DO YOU HAVE?
LOW BACK PAIN ____ LEG PAIN ____ NECK PAIN ____ ARM PAIN ____ NUMBNESS ____ WEAKNESS ____

HAVE YOU SEEN ORTHOPEDIST/NAME? _____
HAVE YOU HAD **X-RAYS:** _____ **MRI** _____ **CT** _____ **DATES**: _____

DATE OF INJURY:_____PLACE OF INJURY:_____
BRIEFLY STATE HOW INJURY OCCURRED:

_____

_____

INSURANCE CARRIER:
_____

SSN: _____

TELEPHONE: _____

ADDRESS: _____

_____

CASE MANAGER:_____

PHONE:_____FAX:_____

CARRIER CASE #:_____

WCB CASE #:_____

HAVE YOU MISSED WORK BECAUSE OF THIS INJURY?: YES NO
IF **YES**,
DATE YOU LEFT WORK:_____

HAVE YOU RETURNED TO WORK?: YES NO
IF **YES**,
DATE OF RETURN TO WORK:_____

EMPLOYER_____SUPERVISOR:_____

ADDRESS:_____TELEPHONE:_____

LAWYER:_____TELPHONE:_____

The undersigned authorizes the release of any information relating to all claims for the benefits submitted on my behalf. I further acknowledge that my signature oh this document authorizes my physician to submit claims for benefits for services rendered without obtaining my signature on each and every claim to be submitted

(SIGNATURE) **(DATE)**