Workers Compensation

Name: _____

Is this an auto related injury?: Yes No

Is this a work related accident?: Yes No

Date of Accident: ____/____/____

Are you Currently working?: Yes No

Job Title: _____

Job Description: _____

WC/No Fault carrier: _____

Claim #: _____ Case #: _____

Claim Address: _____

City: _____ State: _____ Zip: _____

Adjustor Information:

Contact Person: _____

Tel #: _____ Ext.: _____ Fax #: _____

Employer Information:

Name of Employer: _____

Address: _____

City: _____ State: _____ Zip: _____