Name (first, last): _____ Date: _____/_____/_____

Workers' Compensation

Today's visit, is it a **motor vehicle accident** related injury? ❑**Yes** ❑**No**

Yes, please ask for **"NF-3" form**.

Today's visit, is it a **work-related** injury? ❑**Yes** ❑**No**

If **NO, proceed to **Medical History** section. **

Date of Accident/Injury: _____/_____/_____

Approved/Injured body part(s): _____

Have you reported the accident to your employer? ❑**Yes** ❑**No** Currently Working? ❑**Yes** ❑**No**

Employer's Information: *based on date of accident*

Job Title: _____

Job Description/Activities:

_____

_____

Employer's Name: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____-_____

Phone: _____ ext._____ Fax: _____

WCB Case Number: _____

Claim/Carrier Case Number: _____

Employer's Insurance Carrier: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____-_____

Adjustor's Information:

Name (first, last): _____

Phone: _____ ext._____ Fax: _____