COMPENSATION MASTER
WORK RELATED INJURY

Patient's Name: _____ Date of Exam: _____

Employer at the time of injury: _____

Employer Address: _____ City:_____ ST: ____ ZIP:_____

Employer Phone #: _____ Occupation: _____

Present Employer: _____

Address: _____ City:_____ ST: ____ ZIP:_____

Date of injury/occurrence: _____ County injury occurred: _____

How did injury occur? _____

What did you injure? _____

Workers Compensation Insurance Carrier Name: _____

Address: _____ City: _____ ST: _____ ZIP:_____

Carrier Phone #: _____ Contact: _____

Carrier Case #: _____ WCB #: _____ Policy #: _____

I agree to make sure a claim (C2 accident report) is made with my employer and that all proper information is given to this office today or within a week's time from the first visit.

Signature: _____ Date:_____