

WORKERS COMPENSATION INFORMATION SHEET

PATIENT NAME:	
EMPLOYER:	
EMPLOYER ADDRESS:	
	_
WORK COMP INSTIDANCE CARRIED.	
WORK COMP INSURANCE CARRIER:	
ADDRESS:	
	
CLAIM NUMBER:	
DATE OF INJURY:	
ADJUSTOR NAME:	_
ADJUSTOR PHONE #:	
ADJUSTOR FAX #:	
ADJUSTOR EMAIL:	