WORKER'S COMPENSATION

Patient's Information:

First Name: ______________________ MI: ________ Last Name: ______________________

Date of Injury: ______________________ Part of Body Injury Relates to: ______________________

Location (City & State) Where Injury Occurred: ______________________

Send Work Comp Claims to:

Work Comp Carrier Name: ______________________

Mailing Address: ______________________

City: ______________________ State: __________ Zip: __________

Phone: (_____) ______-________ Fax #: (_____) ______-________

Claim #: ______________________

Adjustor's Name: ______________________

Phone: (_____) ______-________ Fax #: (_____) ______-________

Nurse Case Manager: ______________________

Phone: (_____) ______-________ Fax #: (_____) ______-________

Notes: ______________________

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Patient's Attorney Information (if applicable):

Attorney Name: ______________________ Phone: (_____) ______-________

Firm Name: ______________________

Address: ______________________

City: ______________________ State: __________ Zip: __________

Case # (IWCC #) Filed with State of Illinois: __________ WC ______________________

Complete this section only if the employer at the time of injury is different than your current employer

Employer Name: ______________________

Employer Address: ______________________

City: ______________________ State: __________ Zip: __________

Work Phone: (_____) ______-________