Workers' Compensation Claim

Patient Name:_____

Social Security Number:_____ Home Phone#:_____

WCB Number:_____ Carrier Case Number:_____

Date of Injury:_____ Date of Birth:_____

Body Part Covered By Claim:_____

On the date of Injury:

What was your job title/description:_____

What were your usual work activities:_____

Are you working now:_____ If no, what was the last day you worked:_____

Employer when injury occurred:_____

Address:_____

_____

Phone Number:_____

Workers' Compensation Insurance Carrier:_____

Address:_____

_____

Phone Number:_____ Fax Number:_____

Case Manager/Adjustor:_____

Phone Number:_____ Fax Number:_____

_____ _____

Signature **Date**