# WORKER'S COMPENSATION INJURY TREATMENT

NAME: _____
FIRST MIDDLE INITIAL LAST SR. JR. ETC.

RESIDENCE ADDRESS: _____

_____

MAILING ADDRESS _____

IF DIFFERENT: _____

PHONE NUMBERS: _____
HOME CELL WORK

DATE OF BIRTH: _____ SSN: _____

NAME OF EMPLOYER: _____

ADDRESS OF EMPLOYER: _____

_____

EMPLOYER TELEPHONE NUMBER: _____

DATE OF INJURY: _____

DESCRIBE HOW INJURY OCCURRED: _____

_____

_____

LIST NAMES OF INDIVIDUALS WHO SAW YOUR INJURY OCCUR, OR WITH WHOM YOU HAVE DISCUSSED YOUR INJURY: _____
_____

_____

LIST ALL INJURIES YOU BELIEVE YOU HAVE SUSTAINED: _____

_____

_____

LIST THE NAME(S) OF ANY DOCTORS, CLINICS, HOSPITALS, URGENT CARE CENTERS, ETC. WHO HAVE TREATED YOU FOR THESE INJURIES:

_____

_____

NAME(S) OF INDIVIDUAL(S) AT WORK TO WHOM YOU REPORTED THE INJURY:

_____

NAME(S) OF INDIVIDUALS WHO AUTHORIZED TREATMENT FOR THE INJURY:

_____

_____ _____

EMPLOYEE DATE