Workers Compensation / No Fault Registration Form

☐ Workers Compensation ☐ No Fault (Please Check One)

Patient Name: _____ DOB: _____

Name Of Insurance/Coverage: _____

Claim Address For Insurance/Coverage: _____

_____

WCB Case #: _____ Or Claim #:_____

Carrier Case #: _____ Or Policy #:_____

Date of Injury/Accident: _____ Time Of Injury:_____

Claim Manager/Adjuster: _____

Phone #: _____ EXT:_____ Fax #:_____

Body Part Injured: _____ Currently Working: _____

If Yes, Full Time or Part Time: _____ If No, When Did You Stop: _____

Employer:_____ Occupation:_____

Employer Address:

_____

_____

Employer Phone #: _____ Ext:_____ Fax #:_____

Please Explain How Injury Occurred:

_____

_____

_____

Signature: _____ Date: _____