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Workers' Compensation Approval Form

Patient Instructions: Please provide this form to your employer. Your employer will need to complete and sign this form. Once completed, please return this form to our office or have your employer return it by fax.

Employer Instructions: Please complete this form and return a signed copy to your employee. Please sign and date at the bottom indicating this was a workplace injury and that the claim has been reported to your insurance carrier.

Patient (Employee) Information

Last Name: First Name: Middle:

Date of Birth: Social Security Number:

Sex: Date of Injury: ___ / ___ / _____

Employer Information

Employer: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone: (____) _____ - _____ Fax No: (____) _____ - _____

Workers' Compensation Carrier

Insurance Carrier: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone: (____) _____ - _____ Fax: (____) _____ - _____

Adjuster Name: _____ Policy Number _____

Claim/File No.: _____ Date Reported: ____ / ____ / _____

Signature of party, responsible for reporting injury to the workers' compensation carrier.

X_____Date: ___ / ____ / _____