# Worker's Compensation Case Information

***PATIENT***

Name of Patient:________________________________ SS#_____-______-______

Date of injury:________________________________Time:__________________

Address of injury:______________________________________________________

***EMPLOYER***

Employer:______________________________________________________________

Address:_______________________________________________________________

_______________________________________________________________________

Phone: (______)__________________ Injury reported: ☐yes ☐no

To whom:________________________

***INSURANCE***

Employer's insurance company:__________________________________________

Address:_______________________________________________________________

_______________________________________________________________________

Phone:(______)__________________ Contact person:________________________

WCB#__________________________ CC#_____________________________

***ATTORNEY***

☐ I have an attorney. ☐ I do not have an attorney, but plan to get one. ☐ I do not plan to get an attorney.

Attorney name:______________________________Phone(_____)______________

Address:_______________________________________________________________

_______________________________________________________________________

Additional information:_________________________________________________

_______________________________________________________________________

_______________________________________________________________________