Workers Compensation or Auto Insurance Information

Type of Injury:_____ Date of Injury:_____

Have you missed work due to injury? Y / N Date disability began:_____

Returned to work? Y / N Date Returned:_____ Full Duty or Modified/Limited Duty?

Insurance Carrier Name:_____

Insurance Address:_____

City:_____ State:_____ Zip:_____

Claim Number:_____ Contact Person:_____

Phone Number:_____ Extension:_____

Employer Information

Employer Name:_____

Employer Address:_____

City:_____ State:_____ Zip:_____

Employer Phone Number:_____

Employer Fax Number:_____