Andersonville Physical Therapy

WORKERS' COMPENSATION INFORMATION FORM

PATIENT NAME: _____

TODAY'S DATE: _____

EMPLOYER'S NAME: _____

EMPLOYER'S PHONE #: _____

JOB TITLE: _____

DATE OF INJURY: _____

Is this an approved Workers' Compensation injury? yes no

If no, please explain: _____

_____

CLAIM MANAGEMENT COMPANY: _____

CLAIM NUMBER: _____

NAME OF ADJUSTOR: _____

ADJUSTOR'S PHONE NUMBER: _____