WORKMAN'S COMPENSATON FORM

PLEASE READ THIS FORM CAREFULLY!!

You must notify your employer of injury or illness for this claim to be processed. **Failure to do so makes you personally responsible to pay for any treatment received!** All information below must be filled in accurately. This allows us to bill your employer's insurance company for your work related injury. If for some reason you do not have the necessary information to complete this form, please ask someone at the desk to allow you to use the phone in order to obtain the correct information from **your employer.**

Date of Injury:_____ Was this work related?_____

Name of Employer: _____

Company Address: _____

Supervisor: _____ Phone: _____

Employer's
Insurance Carrier: _____

Your Adjuster: _____ Phone: _____

Claim Number: _____

Billing Address: _____

City and State: _____

I have read and filled in the above information to the best of my knowledge. I understand that this information is necessary for the workman's compensation carrier to pay for my account. I also understand that my failure to report this accident/illness to my employer makes me personally responsible for this account.

Signed: _____

Date: _____