Worker's Compensation Statement

Patient Injury Information:

Name of Injured: _____

Date of Injury: _____

Time of Injury: _____

Employer: _____

Phone # of Employer Contact: _____

Who was injury reported to: _____

Medical Treatment: (Nurse / M.D.) _____

Missed Work: (Yes / No) Dates: _____

Work Restrictions: (Yes / No) _____

Daily Employment Activities: _____

_____

_____

Patient Statement of Injury: _____

_____

_____

_____

_____

_____

_____

The above statement / description of my injury(s) happened while in the course of my "normal work activities." (Yes / No)

Patient Signature: _____

Date: _____