



east lincoln family health professionals, pc

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### Workers' Compensation Form

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Parent(s)/ Guardian Name: \_\_\_\_\_

Address: \_\_\_\_\_ Phone: \_\_\_\_\_

\_\_\_\_\_

Today's Date: \_\_\_\_\_ Date of Injury: \_\_\_\_\_

Claim Number: \_\_\_\_\_

Employer's Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Employer Address: \_\_\_\_\_

Adjuster: \_\_\_\_\_ Phone: \_\_\_\_\_

Name and Address to send claim(s): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Explain how injury occurred:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

*I authorize the release of any medical information necessary to process any WC claims. I understand that ALL information needs to be completed on this form. Failure to provide ALL information or return of this form will result in claims not being filed resulting in you being responsible for these services.*

\_\_\_\_\_  
*Signature of Patient/Guardian*

\_\_\_\_\_  
*Date*