E·L·F·H·P

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Workers' Compensation Form

Patient Name: _____DOB: _____

Address: _____ Phone: _____

_____

Today's Date: _____ Date of Injury: _____

Claim No._____

Employer's Name: _____

Address: _____ Phone: _____

_____

Employer's Human Resource or Contact handling WC claim: _____ Phone: _____

Employer's WC Insurance / Who Claim(s) should be sent: _____
Address to Send Claim (s):

_____

_____

Including Date of Injury, give a brief description of what 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 *Date*