

***** Please fill out this form as detailed as possible for WCB insurance purposes *****

WCB Claim #: _____ Date of Injury (mm/dd/yy): _____

Worker's Name: _____ Worker's Job Title: _____

How did you get injured? _____

Did you have similar problems before? ☐ Yes ☐ No _____

Did you see a doctor immediately after injury occurred? ☐ Yes ☐ No

Doctor's Name: _____ Phone: _____

Clinic / Hospital: _____ Date of Visit (mm/dd/yy): _____

Family Doctor: _____ Phone: _____

Did you report the incident to your Employer? ☐ Yes ☐ No

Manager's Name: _____ Employer's Phone: _____

Company Name & Address: _____

Have you lost time from work due to injury? ☐ Yes ☐ No _____

If yes, have you returned to work? ☐ Yes ☐ No _____

Date of return to work (mm/dd/yy): _____

Patient's Signature: _____ Date: _____

Patient's Name: _____
(please print)