

Worker's Compensation Information

Name _____ Exact Date of Injury _____

Employer _____ Personnel Manager _____

Your Supervisor _____ Phone# _____

W/C Insurance Co _____ Phone# _____

Ins Co Address _____

Adjuster _____ Claim# _____

Utilization Review Co _____ Phone# _____

Case Manager/Nurse _____ File# _____

Have you hired and Attorney? _____ Who? _____