

W/C INFO FORM

Name: _____ Exact Date of Injury _____

Employer: _____ Personnel Manger: _____

W/C Insurance Co: _____ Phone (_____) _____

Ins. Co. Address: _____

City: _____ State _____ Zip _____

Adjuster: _____ Claim #: _____

UR Company _____

Phone:(_____) _____ Fax (_____) _____

Case Manger/Nurse: _____