W/C INFO FORM

Name:_____ Exact Date of Injury_____

Employer:_____ Personnel Manger:_____

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

Ins. Co. Andress:_____

City:_____ State_____ Zip_____

Adjuster:_____ Claim #:_____

UR Company _____

Phone:(_____)_____ Fax (_____)_____

Case Manger/Nurse:_____