WORKMAN'S COMPENSATION / ON THE JOB ACCIDENT

LAST NAME	FIRST NAME	DATE OF BIRTH

DATE OF INJURY	CLAIM NUMBER

EMPLOYER	ADDRESS OF EMPLOYER

PHONE NUMBER	FAX NUMBER	SUPERVISOR

Was this injury reported to your employer? ☐Yes ☐No

If yes, reported to whom?

In your own words, describe how, when, and where this accident occurred. ______________________________

____

____

____

____

If you have an attorney, please provide us with the following information.

ATTORNEY'S NAME	PHONE NUMBER	ADDRESS

☐ I understand that if this Workman's Compensation claim is denied by the insurance carrier and/or my employer, I am financially responsible to pay Cedar Point Health for services rendered to me.

______________________ ______________________ __________

PATIENT NAME (PRINT) SIGNATURE DATE

______________________ ______________________

PERSON SIGNING ON BEHALF OF PATIENT RELATIONSHIP TO PATIENT