Amandeep Pal M.D. PLLC

Workers Compensation Information Worksheet

DATE_____

NAME _____

EMPLOYER_____

ADDRESS_____

_____

EMPLOYER PHONE #_____

EMPLOYER COMPENSATION INSURANCE CO_____

ADDRESS AND PHONE _____

DATE DESCRIBE HOW INJURY OCCURRED_____
_____

WHERE DID INJURY OCCUR_____

DID YOU REPORT INJURY TO EMPLOYER? Y / N

HAVE YOU HAD A SIMILAR INJURY IN THE PAST? Y/N
IF YES PLEASE GIVE DATE _____

ARE YOU CURRENTLY WORKING? Y/N
IF NO, FIRST DATE OF YOUR DISABLILITY_____

I UNDERSTAND THAT IF THE INSURANCE CARRIER DENIES PAYMENT FOR ANY REASON THAT I AM FULLY RESPONSIBLE FOR PAYMENT OF SERVICES.

SIGNATURE_____

DATE OF INJURY _____