

Workers Comp Information

Name: _____ Date of Birth: ____/____/____

Employer: _____

Employer Address: _____

Caseworker: _____

Phone Number of Caseworker: (____) _____

Fax Number of Caseworker: (____) _____

Insurance Carrier: _____

WCB #: _____

Carrier Case #: _____ Date of Accident: ____/____/____

Social Security Number: _____

Attorney: _____

Attorney Address: _____

Attorney Phone Number: (____) _____

Attorney Fax Number : (____) _____

Third Party Attorney: (pending lawsuit) _____