WORKER COMPENSATION QUESTIONNAIRE

PHYSICAL REHABILITATION CENTER OF TULSA

Please fill in ALL blanks.

_____

Patient last name First name Middle initial

WORKERS COMPENSATION INSURANCE INFORMATION

_____-____-_____

Workers Compensation Insurance Company Name **Date of injury**

_____

Insurance address

_____( )_____-_____

City State Zip Phone number

_____

Adjuster's name Claim number

Was a Form 3 Filed? YES OR NO
Circle one

_____(____)_____-_____

Attorney name Attorney phone number

_____

Attorney address

_____(____)____-_____

City State Zip Attorney fax number

_____

Contact person's name

_____

Name of Employer **at time of accident.**

_____

Employer's address

_____( )_____-_____

City State Zip Employer's phone number

_____

Area or body part injured

Explain how your injury happened in your own words:

_____

_____

_____

_____