OALI WORKERS' COMPENSATION REGISTRATION

Referring Physician:_____

Referring Physician Phone#:_____

1. Carrier Case#:_____ WCB#:_____
2. Last Name:_____ First Name:_____
3. Social Security#: _____Date of Birth: _____ Gender: M F
4. Street Address: _____ City: _____
5. State: _____ Zip: _____ Home Phone#: _____
6. Cell Phone#: _____
7. Date of Injury/onset of illness: _____ Body Part: _____
8. On the date of injury/illness what was the patient's job title: _____
9. Briefly describe how and where injury occurred: _____

   _____

10. Are you presently working? Yes____ No____ If 'No' when did you stop?_____

    If 'Yes', are you on Regular Duty? _____ Light Duty?_____

    If you stopped, when did you return? _____
11. Employer at time of injury:_____

    Employer Address:_____ City:_____

    State:_____ Zip:_____ Employer Phone:_____

    Contact:_____
12. Employer's WC Insurance Carrier: _____

    Carrier Address: _____ City: _____

    State: _____ Zip:_____ Adjuster Name: _____

    Adjuster Phone#: _____

In the event I fail to prosecute the claim for Worker's Compensation for this illness or condition or it is determined by the Worker's Compensation Board that the illness or condition is not a result of a compensable Worker's Compensation case, I hereby agree to pay (Physician Name) _____ the usual and customary fees for services rendered to the above claimant. I authorize the provider to release any information necessary to substantiate a claim.

Signature: _____ Date: _____

Rev. 2/21/11