

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: _____