



## Workers' Compensation Approval Form

**Patient Instructions:** Please provide this form to your employer. Your employer will need to complete and sign this form. Once completed, please return this form to our office or have your employer return it by fax.

**Employer Instructions:** Please complete this form and return a signed copy to your employee. Please sign and date at the bottom indicating this was a workplace injury and that the claim has been reported to your insurance carrier.

### Patient (Employee) Information

Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_ Middle: \_\_\_\_\_  
Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Social Security Number: \_\_\_\_ - \_\_\_\_ - \_\_\_\_  
Sex: Male Female Date of Injury: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

### Employer Information

Employer: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_  
Telephone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Fax No: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

### Workers' Compensation Carrier

Insurance Carrier: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ ZIP: \_\_\_\_\_  
Telephone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
Adjuster Name: \_\_\_\_\_ Policy Number: \_\_\_\_\_  
Claim/File No.: \_\_\_\_\_ Date Reported: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

Signature of party responsible for reporting injury to the workers' compensation carrier.

**X** \_\_\_\_\_

Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_