WORKERS COMP INFO SHEET

Name: ____

DOB:___________________

Address:____

City: ______________________ State: ____________Zip Code: _______________

Phone Number:____________________________

Date of Injury:___________________

Name of Employer:____

Employer Phone number:____________________________

Name of W/C Company:____

Address of W/C Company:____

City: ______________________ State: ____________Zip Code: _______________

Claim #:____________________________________

Adjustor Name: ____

Adjustor Phone Number: ____________________________

Adjustor Fax Number: ____________________________