WEST POINT

PHYSICAL THERAPY CENTER

WORKERS COMPENSATION INFORMATION FORM

Date:_____

Name:_____ **DOB**: _____
Last First

Employer:_____ **Date of Injury**: _____

Reporting Supervisor:_____ **Employer Phone #**:_____

W/C Insurance Co.: _____ **Claim #:** _____

Address: _____ **Phone #:** (____) _____-_____

City: _____ **State**: ____ **Zip**: _____ **Adjuster**: _____

Describe your injury:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Injured Body Part:_____

Do you have an attorney because of this work related accident? Y / N

Attorney: _____ **Phone #:** (_____)_____-_____

Address: _____

Is this claim: Accepted____ Denied____ Litigation____ Delayed____

West Point Physical Therapy Center, Inc.

Would like to take the time to thank you for filling out this form. This information will expedite your authorization for treatment process.