800 N Carriage Pkwy • Wichita, KS 67208
(316) 858-5800 • Fax (316) 858-5850

WORKERS' COMPENSATION FORM

PATIENT NAME ____
DATE OF BIRTH ____
SOCIAL SECURITY NUMBER ____
ADDRESS ____
____

EMPLOYER NAME ____
EMPLOYER ADDRESS ____
____
EMPLOYER TELEPHONE NUMBER ____
CONTACT PERSON ____

HAVE YOU NOTIFIED YOUR EMPLOYER OF YOUR INJURY? _________________
NAME OF PERSON YOU NOTIFIED ____

HAVE YOU RECEIVED PRIOR TREATMENT FOR THIS ACCIDENT? __________
IF YES, PLEASE GIVE NAME OF PROVIDER ________________________________
DATE OF TREATMENT _____________________________________
TYPE OF CARE RECEIVED _________________________________
____

DESCRIBE THE ACCIDENT IN YOUR OWN WORDS
____
____
____

PLEASE STATE ANY INJURIES RESULTING FROM THIS ACCIDENT
____
____

HAVE YOU RETURNED TO WORK SINCE THE ACCIDENT? __________________
IF YES, WHEN? ____

PLEASE NOTE: A REPORT PERTAINING TO THIS INJURY OR ILLNESS MUST HAVE BEEN FILED WITH YOUR EMPLOYER. PAYMENT FOR ANY NON-REPORTED INJURY/ILLNESS OR NON-AUTHORIZED TREATMENT WILL BECOME THE RESPONSIBILITY OF THE PATIENT.

SIGNATURE ___________________________________DATE____________________

RON C. BROWN, MD CHRIS N. BRUNNER, MD DORIS C. BUTLER, MD CONNIE A. DAVIS, MD
STEVE W. DAVIS, MD ROLLAND K. ENOCH, MD TARI M. ERNST, MD DENIS D. KNIGHT, DO
TIFFANY L. LIEURANCE, DO DREW E. SCHULTZ, DO DIANE M. STEERE, MD