On the Job Injury Form

Patient Name: _____ Date of Injury: _____ Time of Injury: _____

Patient's Job Title:_____

Name of Employer/Company:_____

Work Address: _____

Company Phone #: _____Fax #: _____

Name of Supervisor: _____ Supervisor's Phone #:_____

Was the treatment authorized by your Supervisor? Y/N

Please describe in your own words how this injury occurred and what part of the body was injured.

_____

_____

_____

_____

Company Intake Form-For Office Use Only

(all information below must be complete)

Drug Screen Information

☐ 5panel eCup ☐ 10 panel ☐ None

Company Contact/Designated Employee Representative (DER): _____

Secure email address/Fax # for drug screen results:

_____

Billing

☐ Bill to Company ☐ Bill to W/C Carrier

Billing Address: _____

Contact Person Phone #/Email: _____

Fax # for Return to Work Status Note/Company Medical Record: _____

Name of Work Comp Carrier: _____

Address for Claims: _____

CSA Initials: _____ Date: _____