

Workers Compensation Information

Name: _____ Date and time of Injury: _____

City/Town where injury occurred: _____

WCB Case No.: _____ Carrier Case No: _____

Employer Name: _____

Employer Address: _____

Employer Telephone No: _____

Comp Insurance Carrier: _____

Insurance Address: _____

Insurance Telephone No: _____

State how injury occurred: _____

Was this an already existing injury? _____

Have you seen another doctor for this injury? **Yes or No**
If yes, Whom? _____

First day missed from work: _____

First day returned to work: _____

Are you working now? **Yes or No**

AGREEMENT TO PAY MEDICAL COSTS IN THE EVENT OF FAILURE TO PROSECUTE OR IF COMPENSATION CLAIM IS DISALLOWED

In the event I fail to prosecute the claim for workers' compensation for this illness or condition it is determined by the Workers' Compensation Board that the illness or condition is not a result of a compensable workers' compensation case, I, _____, hereby agree to pay Lake Placid Sports Medicine, PLLC, PO Box 790, 29 Church Street, Lake Placid, NY 12946, their usual and customary fees for services rendered to the above named claimant in the above identified case.

Signature: _____ Date: _____

If signed by other than claimant, print below: name, address, and relationship of signer.

Name and Address

Relationship