

AIRPORT MEDICAL CLINIC

WORKERS' COMPENSATION REGISTRATION FORM

Have you been seen at the clinic since March 9, 2009? Yes ___ No ___

PLEASE PRINT CLEARLY

Social Security # _____ Employee ID # _____
(if known)

NAME:

First _____ MI _____ Last _____

Birth date ___/___/___ Gender: Male _____ Female _____

ADDRESS:

Street _____

City _____ State _____ Zip _____

Home Phone # _____ Cell Phone # _____

Work Phone # _____

DATE OF INJURY: _____

SSN: _____ or CLAIM #: _____ (You must provide either one)

Describe Injury: _____

EMPLOYER: _____

Who authorized your visit? _____

I have been offered a copy of NorthWorks Privacy Policy

Signature _____ Date _____

*****Clinic Use Only Below This Line*****

Work Comp Carrier _____ Claim # _____

Work Comp Address: _____

City _____ State _____ Zip _____

Phone _____ Fax _____ Adjuster _____