

Office Phone: 610-265-5795 | **Fax:** 610-992-9022

WORK-RELATED INJURY REPORT FORM

Universal injury or accident statement	
Omversal injury or assident statement	
Last Name First Name	MI Today's Date
Please complete the following statement. Most insurance companies request accident	t details and this may be forwarded with your insurance claim or provided to an adjuster to
complete your claim. Please complete the sections that apply to your injury and sign at the bottom of the form.	
Dateofinjury	
Place where injury occurred (work, home, parking lot, car, friend's house, etc.)	
Please describe how the injury or accident occurred	
Made valeted initial	Third wast dishility a attlement
Work related injury	Third party liability settlement
Was the injury work related? Yes No (If yes, complete this section)	Is there a possible third party liability settlement? (e.g., auto, homeowners, property)
Name of Employer	Yes No (If yes, complete this section)
Telephone #	
Employer's Address	Name of Insurance
City State Zip	Telephone #
Workman's Compensation Carrier	Adjuster's Name (if known)
Policy # Group #	Telephone #
Claims Address	
City State Zip) (
5 Authorization	
I certify that this information is true and accurate. I hereby authorize the release of a copy of this form as may be necessary to obtain reimbursement from any insurance company which	
may request information regarding my injury and the nature of the treatment. I also understand that I am responsible for responding promptly to my insurance carrier if they request any	
additional information, and that failure to provide requested information may categorize my treatment as a "non-covered" service and may make me personally liable for the medical	
charges incurred.	
Patient Name (or signature of responsible party)	Today's Date