Pain Institute Of Long Island Workers Comp Case

Do you have more than one WC case? Yes, please complete form for each case No Carrier Case #: WC Case #: Body Part Injured: Mid and Lower Back Neck Left Shoulder Right Shoulder Left Knee Right Knee Other: Employer at time of Accident: Employer Address: Name of Supervisor/Manager: Are you currently working No Yes When did you return to work? Workers Compensation Insurance Carrier: Address: Workers Comp Case Manager: Fax : Internal Use:	Today's Date:	_	
Date of Accident: Location of Accident: Do you have more than one WC case? Yes, please complete form for each case No Carrier Case #: WC Case #: Body Part Injured: Mid and Lower Back Neck Left Shoulder Right Shoulder Left Knee Right Knee Other: Employer at time of Accident: Employer Address: Name of Supervisor/Manager: Are you currently working No Yes When did you return to work? Workers Compensation Insurance Carrier: Address: Workers Comp Case Manager: Fax : Employer Telephone Number: Fax : Telephone Number: Telephone Number: Fax : Telephone Number: Tele			
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Case Manager Telephone Number: Fax : Internal Use:	Address:		
Internal Use:	Workers Comp Case Manager:		
	Case Manager Telephone Number:	Fax :	
Date Confirmed:			
Staff Initials:	Date Confirmed:		