



Comprehensive Diagnostic Imaging & Radiology

WORKERS COMPENSATION WORKSHEET

NAME OF CLAIMANT: _____

DATE OF INJURY: _____

EMPLOYER NAME: _____

EMPLOYER ADDRESS: _____

EMPLOYER PHONE NUMBER: _____

WCB CASE NUMBER (WCB AUTH #): _____

CARRIER CASE # : _____

INSURANCE CARRIER: _____

CARRIER ADDRESS: _____

PATIENT'S SOCIAL SECURITY NUMBER: _____

PATIENT'S SIGNATURE: _____

DATE OF SIGNATURE: _____