MEIER FAMILY CHIROPRACTIC

WORKERS COMPENSATION

NAME:______________________ DATE:_____________

EMPLOYER:______________________________ PHONE:____________________

MANAGER:______________________________ PHONE:_____________________

DATE OF INJURY:__________DATE_________TIME___________________PLACE

WORKERS COMPENSATION COMPANY:__________________________________

ADDRESS TO SUBMIT CLAIMS:____

CITY, STATE, ZIP:____

PHONE:_____________________________

FAX:_________________________________

ADJUSTER HANDLING YOUR CLAIM:__________________________

PHONE NUMBER AND DIRECT EXTENSION:________________________________

CLAIM NUMBER:____