



6200 E. Central • Wichita, KS 67208
(316) 858-5800 • Fax (316) 858-5850

WORKERS' COMPENSATION FORM

PATIENT NAME _____
DATE OF BIRTH _____
SOCIAL SECURITY NUMBER _____
ADDRESS _____

EMPLOYER NAME _____
EMPLOYER ADDRESS _____

EMPLOYER TELEPHONE NUMBER _____
CONTACT PERSON _____

HAVE YOU NOTIFIED YOUR EMPLOYER OF YOUR INJURY? _____
NAME OF PERSON YOU NOTIFIED _____

HAVE YOU RECEIVED PRIOR TREATMENT FOR THIS ACCIDENT? _____
IF YES, PLEASE GIVE NAME OF PROVIDER _____
DATE OF TREATMENT _____
TYPE OF CARE RECEIVED _____

DESCRIBE THE ACCIDENT IN YOUR OWN WORDS

PLEASE STATE ANY INJURIES RESULTING FROM THIS ACCIDENT

HAVE YOU RETURNED TO WORK SINCE THE ACCIDENT? _____
IF YES, WHEN? _____

**PLEASE NOTE: A REPORT PERTAINING TO THIS INJURY OR ILLNESS MUST
HAVE BEEN FILED WITH YOUR EMPLOYER. PAYMENT FOR ANY NON-
REPORTED INJURY/ILLNESS OR NON-AUTHORIZED TREATMENT WILL
BECOME THE RESPONSIBILITY OF THE PATIENT.**

SIGNATURE _____ **DATE** _____