

# OALI WORKERS' COMPENSATION REGISTRATION

Referring Physician: \_\_\_\_\_

Referring Physician Phone#: \_\_\_\_\_

1. Carrier Case#: \_\_\_\_\_ WCB#: \_\_\_\_\_
2. Last Name: \_\_\_\_\_ First Name: \_\_\_\_\_
3. Social Security#: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Gender: M F
4. Street Address: \_\_\_\_\_ City: \_\_\_\_\_
5. State: \_\_\_\_\_ Zip: \_\_\_\_\_ Home Phone#: \_\_\_\_\_
6. Cell Phone#: \_\_\_\_\_
7. Date of Injury/onset of illness: \_\_\_\_\_ Body Part: \_\_\_\_\_
8. On the date of injury/illness what was the patient's job title: \_\_\_\_\_
9. Briefly describe how and where injury occurred: \_\_\_\_\_  
\_\_\_\_\_
10. Are you presently working? Yes \_\_\_ No \_\_\_ If 'No' when did you stop? \_\_\_\_\_  
If 'Yes', are you on Regular Duty? \_\_\_\_\_ Light Duty? \_\_\_\_\_  
If you stopped, when did you return? \_\_\_\_\_
11. Employer at time of injury: \_\_\_\_\_  
Employer Address: \_\_\_\_\_ City: \_\_\_\_\_  
State: \_\_\_\_\_ Zip: \_\_\_\_\_ Employer Phone: \_\_\_\_\_  
Contact: \_\_\_\_\_
12. Employer's WC Insurance Carrier: \_\_\_\_\_  
Carrier Address: \_\_\_\_\_ City: \_\_\_\_\_  
State: \_\_\_\_\_ Zip: \_\_\_\_\_ Adjuster Name: \_\_\_\_\_  
Adjuster Phone#: \_\_\_\_\_

In the event I fail to prosecute the claim for Worker's Compensation for this illness or condition or it is determined by the Worker's Compensation Board that the illness or condition is not a result of a compensable Worker's Compensation case, I hereby agree to pay (Physician Name) \_\_\_\_\_ the usual and customary fees for services rendered to the above claimant. I authorize the provider to release any information necessary to substantiate a claim.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_