Pain Institute Of Long Island
Workers Comp Case

Today's Date: ___________________________

Name:________________________________ Date of Birth: ____________________________

SSN: ___________________________________

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?___________________________________

<u>Workers Compensation Insurance Carrier</u>:

____

Address: ____

Workers Comp Case Manager:____

Case Manager Telephone Number: ____________________ Fax :__________________

<u>Internal Use:</u>
Date Confirmed: _______________
Staff Initials: _______________