

# Worker's Compensation Registration Form

Jefferson Primary Care

116 East Third St.

Ranson, WV 25438

304-724-7200

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ M F M S D W  
(last, first, middle) (Gender) (Marital Status)

Home Address: \_\_\_\_\_ Home Phone: \_\_\_\_\_  
(street, city, zip code)

Cell Phone: \_\_\_\_\_ SSN: \_\_\_\_-\_\_\_\_-\_\_\_\_ Employment Status : FT PT (# hrs/wk \_\_\_\_)

Employer: \_\_\_\_\_

Employer Address: \_\_\_\_\_  
(street, city, zip code)

Employer Phone Number: \_\_\_\_\_ Employer Fax: \_\_\_\_\_

Date of accident \_\_\_\_\_ Time of accident: \_\_\_\_\_ am/pm Day of week: \_\_\_\_\_

What was being done before accident occurred? \_\_\_\_\_

Describe the accident in detail (use additional sheets if necessary):

Was this part of normal job duty? Y N Body part(s) affected or injured: \_\_\_\_\_

Type of injury sustained: \_\_\_\_\_

Was the accident reported to employer?  Yes  No Date accident reported to employer: \_\_\_\_\_

If yes, to whom? \_\_\_\_\_ Phone Number: \_\_\_\_\_

Was accident reported to your employer's workers compensation carrier?  Yes  No

Name of workers compensation carrier: \_\_\_\_\_

Who reported? \_\_\_\_\_ Workers Comp Claim #: \_\_\_\_\_

Workers Comp Adjuster Name: \_\_\_\_\_ Adjuster Contact #: \_\_\_\_\_

Workers Comp Claims Address: \_\_\_\_\_  
(street, city, zip code)

**PATIENT SIGNATURE:** \_\_\_\_\_ **DATE:** \_\_\_\_\_