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FAMILY MEDICINE OCCUPATIONAL HEALTH

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INJURED WORKER REGISTRATION FORM

INJURED WORKER'S NAME: ....

ADDRESS: ....

....

TELEPHONE: .... DATE OF BIRTH: ____ / ____ / ____

DATE OF INJURY: ____ / ____ / ____

TYPE OF INJURY: ....

....

BROUGHT IN BY: ....
(PLEASE PRINT NAME)

COMPANY / PERSON
RESPONSIBLE FOR ACCOUNT: ....

ADDRESS: ....

....

DIVISION/BRANCH: ....

DATE OF ATTENDANCE: ____ / ____ / ____

I HEREBY ACKNOWLEDGE THAT IF THIS CONSULATION IS DEEMED *NOT WORK RELATED* FOR ANY REASON, OR MY CLAIM IS REJECTED BY EITHER THE COMPANY OR INSURANCE COMPANY THAT I AM LIABLE FOR *ALL COSTS* INCURRED IN RELATION TO THIS MATTER *WITHIN 30 DAYS* OF THE APPOINTMENT.

SIGNATURE OF PATIENT: .... **DATE :** ____ / ____ / ____

QIP/AGPAL
SPECIALIST IN ACCREDITATION,
QUALITY AND RISK MANAGEMENT