VALEWOOD CLINIC
ABN 66 420 561 884
FAMILY MEDICINE OCCUPATIONAL HEALTH

A: 1 Wanda Street, Mulgrave Vic 3170
T: (03) 9560 6655 (03) 9560 6510
F: (03) 9561 5317
E: staff@valewoodclinic.com.au
W: www.valewoodclinic.com.au

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: / /

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

>**Dr P A GILES** M.B.B.S., Dip. R.A.C.O.G., Grad.Dip.Occ.H. Prov. No. 470 581 X
>**Dr P J LACKNER** M.B.B.S., F.R.A.C.G.P., Dip.Sports Med. Prov. No. 95340 EW
>**Dr M A KILEY** M.B.,BS F.R.A.C.G.P., Prov. No. 95399 JX
>**Dr S BANSAL** M.B.B.S., F.R.A.C.G.P., Prov. No. 252 6157 A
>**Dr A HERATH** B.A.B.Sc., B.M.B.S., F.R.A.C.G.P. Prov. No. 2474348 W
>**Dr P BEVZ** M.B.B.S. 0193675 J

QIP/AGPAL
SPECIALIST IN ACCREDITATION, QUALITY AND RISK MANAGEMENT

>**Dr L M O'KEEFE** M.B.B.S. Prov. No. 365 895 J
>**Dr J SONG** M.B.B.S., F.R.A.C.G.P., Ph.D Prov. No. 229 2627 B
>**Dr F L WILK** M.B.B.S. Prov. No. 327177 Y
>**Dr R TULADHAR** M.B.B.S. F.R.A.C.G.P.D.C.H., Ph.D Prov. No. 2134248F
>**Dr G STABELOS** MB., BS., B.App.Sc(Chiro.) Grad. Dip. Exercise & Sports Sc FIACA, FRACGP., Prov No. 2736208B