MOSIER/TIMPERLEY CHIROPRACTIC CLINIC
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Work Related Injury

Name: _____

Date of Accident: _____ Time of Accident: _____ A.M/P.M

Location of Accident: _____

Was your accident directly related to your work? (Yes/No)

Did you fill out an accident report (Yes/No)

Did you report the injury to your foreman or employer? (Yes/No) If yes, whom?_____

Does your employer know you are here today? (Yes/ No)

Was anyone present during your accident (Yes/No)

What recommendations did your Employer make just after your accident? _____

_____

Did your employer ask who your primary doctor was? (Yes/No)

Did your employer tell you what doctor you should see? (Yes/No)

Employer: _____ Phone: _____

Contact person: _____ Phone: _____

Claim #: _____ Insurance Adjuster: _____

Address: _____

Signature: _____ Date:_____