

EMERGENCY ONE
URGENT CARE & DIAGNOSTIC CENTER
40 HURLEY AVE SUITE 4 KINGSTON, NY 12401
845-338-5600 FAX 845-338-3058
4250 ALBANY POST RD SUITE 1 HYDE PARK, NY 12538
845-229-2602 FAX 845-229-2830

WORKERS' COMPENSATION INFORMATION SHEET/CONSENT FORM

NAME OF INJURED PERSON: _____
INJURED PERSON'S JOB TITLE: _____
LIST USUAL WORK ACTIVITIES ON DATE OF INJURY: _____
INJURED PERSON'S SOCIAL SECURITY NUMBER: _____

WCB CASE# _____ **CARRIER CASE#** _____
(IF KNOWN) (IF KNOWN)

DATE OF INJURY: _____ **TIME OF INJURY:** _____
ADDRESS WHERE INJURY OCCURRED: _____

HOW DID THIS INJURY OCCUR? _____

INJURED BODY PART(S) _____

DID YOU REPORT INJURY? _____ **YES** _____ **NO**
HAVE YOU BEEN TREATED BY ANOTHER PHYSICIAN FOR THIS INJURY? _____ **YES** _____ **NO**
IF YES, DETAILS: _____
REPORTED TO (MANAGER/SUPERVISOR NAME) _____

EMPLOYER NAME (COMPANY): _____

EMPLOYER CONTACT: _____
(IF DIFFERENT FROM ABOVE)

EMPLOYER ADDRESS(COMPANY): _____

EMPLOYER TELEPHONE(COMPANY)#: _____

EMPLOYER'S INSURANCE CARRIER'S NAME: _____

ADDRESS: _____
POLICY# _____

TELEPHONE # _____

IN THE EVENT THAT I FAIL TO PROSECUTE THE CLAIM FOR WORKER'S COMPENSATION FOR THIS ILLNESS OR CONDITION, OR IT IS DETERMINED BY THE WORKER'S COMPENSATION BOARD THAT THIS ILLNESS OR CONDIITON IS NOT A RESULT OF A COMPENSABLE WORKER'S COMPENSATION CASE, I, _____ HEREBY AGREE TO PAY EMERGENCY ONE URGENT CARE & DIAGNOSTIC CENTER THEIR USUAL AND CUSTOMARY FEES FOR ALL SERVICES RENDERED TO THE ABOVE NAMED CLAIMANT IN THE ABOVE IDENTIFIED CASE. I HEREBY AUTHORIZE EMERGENCY ONE TO RELEASE MEDICAL INFORMATION TO MY EMPLOYER FOR PURPOSES OF HANDLING MY WORK RELATED INJURY AND/OR EMPLOYEE SCREENING.

DATE: _____ **SIGNATURE:** _____

IF SIGNED BY OTHER THAN CLAIMANT, COMPLETE BELOW:

NAME: _____
ADDRESS: _____
RELATIONSHIP TO PATIENT: _____