

SOMERSET ORTHOPAEDICS, INC.
WORKERS COMPENSEATION MEDICAL REPORT CONFIRMATION

Name of Employee: _____

Date of Birth: _____ Social Security # _____

Date of Injury: _____ Reported to Employer: Yes or No
If yes, to whom? _____

Name of Employer: _____

Address: _____

Supervisor: _____

Phone: _____ Fax: _____

What is the nature of injury? _____

Are you disabled as a result of this injury? _____

If yes, when did disability begin (first day you missed work) _____

Name of Workers Compensation Insurer: _____

Address: _____

Claim Number: _____ Adjustor Name: _____

Phone Number: _____ Fax Number: _____

I reported the injury to my auto insurer and I understand that if the claim is not paid that I am responsible for the payment of services. I authorize submission of information pertinent to this claim to be sent to the parties responsible for payment of claims and/or involved in the treatment of this injury.

Signature: _____ Date: _____