Work Comp Client Information

Company Name: _____

Address: _____
_____

Main Contact: _____

Phone Number: _____
Fax Number: _____

Work Comp Co: _____
Address: _____
_____

Policy #: _____
Phone: _____

SPECIAL INSTRUCTIONS

Is Modified Duty Available? **YES _____ NO _____**
Do you wish us to bill your company for 1st aid services? **YES _____ NO _____**
Do you require Post Accident Drug Screens? **YES _____ NO _____**
Reports: Faxed _____ Mailed_____ to: _____ at: _____

Other instructions:

_____
_____
_____
_____

Please provide Corporate information if applicable.

Corporate Name: _____

Address: _____
_____

Main Contact: _____

Phone Number: _____
Fax Number: _____