



Riverside Orthopaedic and Sports  
Medicine Associates, P.C.  
36 West 60<sup>th</sup> Street  
New York, NY 10023  
Tel 212.265.2828 • Fax 212.265.5077

Doctor: \_\_\_\_\_

## WORKERS' COMPENSATION

Was an Automobile involved? \_\_\_\_\_ Date of injury: \_\_\_/\_\_\_/\_\_\_

Injured body part \_\_\_\_\_

Place of Accident: \_\_\_\_\_

Are you still working? \_\_\_\_\_ If no, last date worked \_\_\_/\_\_\_/\_\_\_

Worker's Comp Carrier: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Claim # \_\_\_\_\_ Policy # \_\_\_\_\_

WCB # \_\_\_\_\_

Workers' Comp. Carrier Phone # \_\_\_\_\_

Adjuster (Name of person handling your case) \_\_\_\_\_

Employer at the time of the injury: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Attorney Name: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Attorney Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

In the event I fail to prosecute the claim for Workers' Compensation for this illness or condition or it is determined by the Worker's Compensation Board that the illness or condition is not a result of a compensable Workers' Compensation case I, \_\_\_\_\_ hereby agree to pay Dr. \_\_\_\_\_ his usual and customary fees for services rendered.

I HEREBY AUTHORIZE THE DOCTOR TO RELEASE INFORMATION ACQUIRED IN THE COURSE OF MY EXAMINATION OR TREATMENT TO BE RELEASED TO MY COMPENSATION BOARD AND/OR MY ATTORNEY.

Patient's Signature \_\_\_\_\_ Date: \_\_\_\_\_

*Effective 1/1/05*