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Workers Compensation Registration Form

Worker Information

Patient Name	Date of Birth
Date of Injury	Social Security Number

Employer Information

Employer Name	Employer Contact/Supervisor Name
Employer Phone Number	Employer Contact/Supervisor Phone Number
Employer Address	Employer Contact/Supervisor Fax Number

Workers Compensation Insurance Information

Insurance Company Name	Insurance Company Address
Insurance Company Phone Number	Insurance Company Fax Number
Policy Number	Drug Testing Required? (circle one) In-House 5 panel Chain of Custody 10 panel None Required
Claim Number	Special Instructions?