



CONWAY CLINIC

SPORTS INJURIES • REHABILITATION • CHIROPRACTIC

WORKER'S COMPENSATION AUTHORIZATION

Patient Name _____

Date of Accident _____

Disability: Date Last Worked _____ Date Returned to Work _____

Employer Name _____

 Address _____

 Phone _____

 Person to Contact _____

Worker's Compensation Carrier

 Name _____

 Address _____

 Phone _____

 Person to Contact _____

Do you wish billing to be forwarded to employer or insurance carrier?

Employer

Insurance Carrier

The above patient has advised me of his work-related injury and that he/she is being treated by:

 Provider Name _____

 Address _____

 Phone _____

 Person to Contact _____

Signature Authorized Representative

Date

Please Print Name