

**WORKER'S COMPENSATION**

**DATE** \_\_\_\_\_

**NAME OF COMPANY** \_\_\_\_\_

**ADDRESS** \_\_\_\_\_

\_\_\_\_\_

**PHONE #** \_\_\_\_\_

**INSURANCE COMPANY** \_\_\_\_\_

**ADDRESS** \_\_\_\_\_

\_\_\_\_\_

**PHONE #** \_\_\_\_\_

**CLAIM#** \_\_\_\_\_

**DATE OF ACCIDENT** \_\_\_\_\_

**ATTORNEY'S NAME** \_\_\_\_\_

**ADDRESS** \_\_\_\_\_

\_\_\_\_\_

**PHONE #** \_\_\_\_\_