MEDICAL TREATMENT PROVIDER LIST

(for injured employee to complete)

Claimant Name:_____ Social Security Number:_____
Address:_____ Date of Injury:_____
_____ Employer:_____
Telephone Number:_____ Cell Number:_____

"Notification to the Workers' Compensation Claimant"
We are asking that you please fill out this form to help expedite the Workers' Compensation claim filed.
Please list all the medical providers for industrial injury first.

Please list any other medical providers who have treated you for any medical problems within the past years (up to 15 years)

_____ _____
_____ _____
_____ Zip_____ _____ Zip_____
Telephone Number_____ Telephone Number_____
_____ _____
_____ _____
_____ Zip_____ _____ Zip_____
Telephone Number_____ Telephone Number_____
_____ _____
_____ _____
_____ Zip_____ _____ Zip_____
Telephone Number_____ Telephone Number_____
_____ _____
_____ _____
_____ Zip_____ _____ Zip_____
Telephone Number_____ Telephone Number_____

Please attached additional pages, if necessary

Requesting Party:
Address:
Phone Number:
Fax:
Relationship to the Claimant: Adjuster

Failure to return this form to the requester may result in a delay or denial of your claim Form F