

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