Gateway Urgent Care

HISTORY OF WORK-RELATED ACCIDENT / INJURY

1. Employer Name

2. Employer Address No. and Street City State Zip Code

3. Nature of business (e.g food manufacturing, building construction, retailer of women's clothing)

4. Patient Name (first, middle last) 6. Sex 7. Date of Birth

8. Address No. and Street City State Zip Code

9. Occupation (specific job title) 10. Social Security Number 11. Phone Number

12. Where Did Injury Occur? (Address No. & St City County) 13. Date & Time of Injury

14. Date Last Worked 15. Date & Hour of First exam 16. Have you previously been treated at this facility?

17. Describe how the accident happened.

18.Current complaints from the injury.

Any person who makes or causes to be made, any knowingly false or fraudulent material statement or material representation for the purpose of obtaining or denying workers' compensation benefits or payments is guilty of a felony.

SIGNATURE: E-Mail DATE:

OFFICE USE ONLY:

X-ray Performed: Pending/None Chemical Compound involved: YES/NO FIRST AID: YES/NO

Findings Consistent w acct of injury: YES/NO _____

Any Current Condition that will impede or delay recovery: YES/NO Full Duty/Restrictions