Waukesha Surgical Specialists, S.C. (WSS)

Workers' Compensation Insurance Information

Name:_____ DOB:_____

Explanation of how injury occurred:

_____

_____

_____

Date of Injury:_____

Employer Name:_____

Employer Address:_____

City_____ State_____ ZIP_____

Phone Number:_____ Contact Person:_____

Name of Workers' Compensation Insurance Co.:_____

Insurance Company Address:_____

Claim#_____ City_____ State_____ ZIP_____

Phone Number:_____ Contact Person:_____

Are you currently working?_____
If not, indicate date disability began._____

Any prior disability?_____
If yes, specify._____

Additional
Comments:_____

_____

_____

Signature:_____ Date:_____

REV: 02/04/2015