W.C.B. FORM COASTAL CHIROPRACTIC

Date: ______________________________

Name: ____
(Please print full first, last & middle initial)

Telephone (H): ____________________ Telephone (W): _______________________

Date of birth: __________________________ Claim #: _______________________
(year/month/day)

Employer's name: ____

Employer's Address: ____
(Postal Code) (Work phone number)

Contact name at work place: ____

Date of accident: _____________ Who rendered first treatment: _________________

Off Work Yes No
If yes, from what date: ____

DESCRIPTION OF ACCIDENT: ____

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IF FOR ANY REASON W.C.B. WILL NOT ACCEPT YOUR CLAIM, YOU ARE RESPONSIBLE FOR ALL CHARGES.

______________________________ ______________________________
(Signature) (Date)