GREAT LAKES CANCER CARE

Workers' Compensation Information

Name _____ Date _____

Employer _____

Compensation Insurance Carrier _____
Address _____
Phone _____

Workers' Compensation Case Number _____ Date of Injury _____

How were you hurt?

_____
_____
_____

Referring Physician

_____

WORKERS' COMPENSATION PAYMENT AGREEMENT

I _____, understand that I am responsible for payment in full of any charges related to my care at Great Lakes Cancer Care should my claim for Workers' Compensation for this injury/illness/condition stated above be denied by my employer's medical insurance carrier or Workers' Compensation Board of New York State.

Patient's signature_____ Date _____