Worker's Comp Acknowledgement Form

Please complete this form and return it to the Agility W/C Dept:
Fax: 781-435-1200 -or- Email: workcomp@agilitydoctor.com

Today's Date: _____

Employee Name: _____

Employee Phone #: _____

Commercial Insurance: _____

Primary Care Physician: _____

Date of Injury: _____

Describe the Injury,
Body Part, and Side: _____ Right ☐ Left ☐ Bilateral ☐

(ex: Left knee / Right thigh) _____

Verification Section

Employer Name: _____

Employer Address: _____

_____

Employer Phone #: _____

Employer Supervisor: _____

W/C Claim Number: _____

W/C Insurance Company: _____

W/C Insurance Address: _____

_____

W/C Insurance Phone #: _____

W/C Insurance Fax #: _____

W/C Insurance Adjuster: _____

Agility Orthopedics
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