WCB INTAKE FORM 2

WCB CLAIM NUMBER:	DATE OF INJURY (MM-DD-YYYY)	DATE OF BIRTH:	ALBERTA HEALTH CARE NO:

HAVE YOU LOST TIME FROM WORK (_____Y/_____N)	HAVE YOU RETURNED TO WORK? (___Y/____N)
IF YES: _____DAYS/ _____WEEKS	IF YES: DATE OF RETURN TO WORK (MM-DD-YYYY) _____
WHAT BODY PART:	**TYPE OF INJURY: (I.E. STRAIN, FRACTURE)**

COMPLAINT/SYMPTOMS:
HAVE YOU EVER HAD A SIMILAR PROBLEM? ☐ NO ☐ YES IF YES, PLEASE DESCRIBE:

REFERRAL DOCTOR

DOCTOR WHOM YOU FIRST REPORTED THIS PROBLEM:NAME & CLINIC	FIRST DATE OF DOCTOR CONTACT (YYYY-MM-DD):
DATE OF DOCTOR REFERRAL:	**DOCTOR PHONE:**

FAMILY DOCTOR: (IF DIFFERENT THAN ABOVE)

(IF YOU HAVE A REFERRAL SLIP PLEASE PROVIDE ALONG WITH THIS FORM)

EMPOLYMENT INFORMATION

EMPLOYER:	JOB TITLE:
EMPLOYER CONTACT PERSON: (SUPERVISOR, HR)	**EMPLOYER CONTACT NUMBER:**

EMPLOYER ADDRESS:

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____