

Professional Evaluation Medical Group

Worker's Compensation

Were you injured on the job? _____ Date of injury: _____

Are you still working? _____ If no, last date worked: _____

Worker's Compensation carrier: _____

Address: _____

City: _____ State: _____ Zip: _____

Claim #: _____

Policy #: _____

WCB #: _____

Employer at the time of injury: _____

Address: _____

City: _____ State: _____ Zip: _____

I, _____ hereby authorize payment of Worker' compensation benefits directly to Professional Evaluation Medical Group. In the event that I fail to file a claim for Worker' compensation benefits for this illness or condition, or it is determined by the Worker' compensation carrier that the illness or condition is not a result of a compensable Worker' compensation case, I hereby agree to pay Professional Evaluation Medical Group his usual and customary fees for all services rendered.

I HEREBY AUTHORIZE PROFESSIONAL EVALUATION MEDICAL GROUP TO RELEASE INFORMATION ACQUIRED IN THE COURSE OF MY EXAMINATION OR TREATMENT TO BE RELEASED TO MY WORKER' COMPENSATION CARRIER AND/OR MY ATTORNEY.

Signature:_____

Date:_____