DOCTORS MEDI CENTER
835 Roosevelt Ave
Carteret, NJ 07008
T: 732-969-2240 F: 732-969-2152

WORKERS COMP REGISTRATION

Thank you for choosing Doctors Medi Center to take care of you and your employees. **As an employer**, please fill out this form to the best of your ability ***prior to the employee visit.***

EMPLOYEE INFORMATION

Last Name	First Name	Middle Initial
Date of Birth / /	Occupation	Male Female

COMPANY INFORMATION

Company Name	Employer Contact
Mailing Address	Employer Phone ext.
City State	Employer Email
Zip	Employer Fax

Preferred Method of Contact Mail Phone Email Fax

INJURY INFORMATION

Date of Injury	Time of Injury AM / PM
Did you report this injury to your employer?	
Who did you report this to?	TItle
What job were you performing when this injury occured?	
Body part(s) affected:	
Please provide a detailed explanation of how this injury occured:	

I declare under penalty of perjury that I have examined all statements contained herein, and to the best of my knowledge and belief, they are correct and true. Any person who commits wokers' compensation fraud, upon conviction, shall be guilty of a felony.

I hereby authorize Doctors Medi Center to release/furnish all information concerning my Diagnostic Test, History and Physical Examination. I also assign these physicians all payments for medical services rendered to my department or myself. I understand that regardless of my insurance company or the party requesting this exam, I am ultimately resposible for charges produced by DMC.

Patient Signature_____ **Date**_____