SALCIDO
FAMILY MEDICINE
FRANCISCO SALCIDO, MD - BOARD CERTIFIED

WORKERS' COMPENSATION REGISTRATION

EMPLOYEE INFO

Name _____ DOB _____ SS# _____
Address _____
City _____ State _____ Zip _____
Daytime Phone # _____ Emergency # _____

INJURY INFO

Where did this happen? _____
How did this happen? _____
Were you at work? Yes ❑ No ❑ Date of injury _____
What body part is injured? _____

_____
Who directed you to this office? _____
Have you spoken to the insurance company? Yes ❑ No ❑ Date _____
Have you been treated anywhere else? Yes ❑ No ❑ Where? _____

OFFICE USE ONLY:

EMPLOYER INFO

Employer _____ Ph # _____ Fax# _____
Address _____
Authorizing person _____ Title _____ Ph # _____
Drug Test Yes ❑ No ❑ Alcohol Yes ❑ No ❑
If yes, do you have a lab or COC? Yes ❑ No ❑ DOT ❑ or Non DOT ❑
Who is authorized to pay for drug testing? _____
Will company be filing Work Comp Claim? Yes ❑ No ❑
If yes, complete info below.

INSURANCE INFO (IF FILING A CLAIM)

Work/Comp Carrier _____
Address _____ Ph # _____ Fax # _____
Adjuster _____ Ph # _____ Fax # _____
Claim # _____ DOI _____
Compensable injury/body part injured _____
Any disputes? _____
Policy # _____
Is this network policy? Yes ❑ No ❑ Name of Network _____