EAST HILLS PHYSIOTHERAPY
Unit 303, 409 East Hills Blvd. SE
Calgary, AB T2A 4X7
Ph.: 403-207-1960
Fax: 587 333 0082

WCB Intake form

*****Please fill out this form as detailed as possible for WCB insurance purpose*****

WCB claim # _____ **Date of injury (dd/mm/yyyy)** _____

Worker's Name: _____ Worker's Job Title: _____

How did you get injured? _____

_____

Did you have similar problem before: Yes / No _____

Have you seen any Doctor immediately after injury occurred? Yes / No

If Yes, Provide Doctor's (Name) _____ Phone: _____

When did you see the Doctor (Date-dd/mm/yyyy) _____

Company Name and Address: _____

_____

Employer Phone #: _____ Manager's Name: _____

Nature of Work/ describe your duties at work: _____

_____

Did you Report the incident to Employer: _____

Have you lost time from work due to injury? _____

If Yes, Have you returned to work? _____

Date of return to work: (dd/mm/yyyy) _____

Family Doctor: _____

Patient Signature_____ Date: _____

Print Name: _____