COASTAL REHAB
PHYSICAL THERAPY + SPORTS + SPINE

Worker's Compensation

Employer:		**Occupation:**	
Employer's Address:	**City:**	**State:**	**Zip Code:**
Current Work Status: ☐ Full Duty ☐ Light Duty ☐ Not Working		**Claim Number:**	
Insurance Carrier:		**Phone Number:**	**Fax Number:**
Insurance Address:	**City:**	**State:**	**Zip Code:**
Contact Person/Adjuster:		**Phone Number:**	**Fax Number:**
Adjuster Email:			
Nurse Case Manager:		**Phone Number:**	**Fax Number:**
Case Manager Email:			

Motor Vehicle Accident

Do you have an Attorney involved? ☐ Yes ☐ No		**If Yes, Attorney Name:**	
Attorney Address:	**City:**	**State:**	**Zip Code:**
Phone Number:		**Fax Number:**	

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