ANDERS VICTORIA FAMILY CHIROPRACTIC

W.C.B. INJURY STATEMENT

Personal / Injury Information

First Name:	**Initial:**	**Last Name:**	**Gender M F**

Home Telephone:	**Home Address Including Postal Code:**
Birth date (Yr/Mon/Day)	**Alberta Health Care #:**
WCB Claim #:	**Adjuster Name:**
Employer:	
Supervisor:	
Address & Postal Code:	**Telephone:**
Date & Time of Accident:	**Time Lost YES NO**
Job Position: **Job Description:**	**Have you injured the area before?** **If yes, explain:**

Have you seen a different doctor in regards to this injury: YES NO
If yes, Name of Doctor: Name of Clinic:
Date:

Modified or Alternate Work Available:
If yes, What is it?

Can it be Performed?

Job Requirement: (Circle One)
Light Duties Medium Duties Heavy Duties

Job Requirement Approved by:

Description of Accident:

How did the injury happen? What were you doing?
Describe your position, pain, & body area that was injured.
How has this affected your ability to move, work, walk, sit, or sleep?
How has this changed your life?
The more accurate & extensive your statement, the more informed Dr. Corey or Dr. Andrea will be when reporting your claim to WCB.

If for any reason W.C.B. will not accept your claim, you are responsible for all charges.

Signature _____ Date _____