3 Mount Shadforth Rd
Denmark Western Australia 6333
Telephone: 08 9848 4111
Facsimile: 08 9848 2192
Email: admin@denmarkmedicalcentre.com.au

Accredited Genera Practice

WORKERS COMPENSATION VERIFICATION FORM

PATIENT TO COMPLETE

Patient Name: ____

Home Address: ____

Home Phone: __________________________ Mobile Phone: ___________________________

Date of Injury: __________________________ Site of Injury: ___________________________

Business Name: _________________________ Supervisor: ______________________________

Employers Address: ____

Employers Phone: _________________________

Briefly describe injury and how it occurred:
____
____
____
____

Has the injury been reported to your supervisor: YES NO

Is this a recurrence of a previous Workers Compensation claim? YES NO

Details of previous claim: ____

I acknowledge I have commenced a Workers Compensation claim at Denmark Medical Centre.
Please tick ☑

☐ I hereby acknowledge that if my Workers Compensation / Motor Vehicle injury claim is not accepted by the insurer, the account will then become my responsibility. I agree to settle my account within one week of notification of non-acceptance of the claim.

☐ I also acknowledge that if Denmark Medical Centre has not received an approved claim number within thirty (30) days, I will be expected to settle my account after each consultation until further notice.

Patient Signature: _________________________________Date: __________________________