INFINITY ORTHOPEDICS

FOR WORKERS COMPENSATION/IME/PERMANENCY EXAMS ONLY

PLEASE FILL OUT THE FOLLOWING AS IT PERTAINS TO YOU

EMPLOYER_____OCCUPATION_____

EMPLOYER ADDRESS_____CITY_____STATE_____ZIP_____

EMPLOYER PHONE NUMBER_____

DATE OF INJURY_____

ARE YOU CURRENTLY WORKING? YES_____NO_____ IF YES, FULL DUTY_____LIGHT DUTY_____

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ADJUSTER/NURSE CASE MANAGER NAME_____COMPANY_____

PHONE NUMBER_____

CLAIM NUMBER_____

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ARE YOU INVOLVED IN A LAWSUIT /OR HAVE A LAWYER FOR YOUR INJURIES? YES_____NO_____

IF YES:

LAWYER NAME_____PHONE NUMBER_____

LAWYER ADDRESS_____CITY_____STATE_____ZIP_____

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BY SIGNING BELOW I UNDERSTAND THAT TREATMENT RENDERED IS FOR A WORKER'S COMPENSATION, INDEPENDENT MEDICAL EXAM, OR PERMANENCY EXAM. I UNDERSTAND THAT I MUST COMPLY WITH THE TREATMENT AND/OR MEDICAL ADVICE GIVEN TO ME BY INFINITY ORTHOPEDICS OR THERE MAY BE INTERRUPTION IN MY TREATMENT OR EMPLOYMENT STATUS.

ALL QUESTIONS REGARDING TESTING OR OTHER TREATMENTS, INCLUDING PHYSICAL THERAPY, AS PRESCRIBED BY THIS OFFICE MUST BE DIRECTED TO MY CLAIMS ADJUSTER/NURSE CASE MANAGER/LAWYER. INFINITY ORTHOPEDICS DOES NOT DICTATE WHERE YOUR OTHER TREATMENTS TAKE PLACE.

SIGNATURE_____DATE_____