**WOONONA PHYSIOTHERAPY**

**& SPORTS INJURY CLINIC**

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A.P.A. SPORTS PHYSIOTHERAPIST

**CTP/WORKERS COMPENSATION CLAIMS INFORMATION**

|  |
| --- |
| **NAME:** |

|  |  |
| --- | --- |
| **EMPLOYER DETAILS**  **EMPLOYER:** | |
| **EMPLOYER’S ADDRESS:** | |
| **PHONE:** | **FAX:** |
| **CONTACT NAME:** (Person dealing with compensation issues) | |

|  |  |
| --- | --- |
| **INSURANCE COMPANY DETAILS**  **INSURANCE COMPANY:** | |
| **INSURANCE COMPANY’S EMAIL:** | |
| **PHONE:** | **FAX:** |
| **CONTACT NAME:** | |
| **CLAIM No:** | |
| **NATURE OF INJURY:** | |
| **DATE OF INJURY:** | |

*I understand that it is my responsibility to make sure that the insurance company has received all relevant documents relating to this insurance claim, and any expenses for treatment that are not covered by the insurance company therefore become my responsibility.*

*I give permission for Woonona Physiotherapy to release information related to my treatment to outside organizations; on request from appropriate persons.*

Signed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: / /