Lockport Family Chiropractic
Health and Wellness Centre

W.C.B. WORK ACCIDENT REPORT

Name:_____

Home phone:_____**Business phone**:_____

WCB Claim #_____

Employer_____

Employer Address_____

Job Title_____

Date of Accident_____ **Time**_____

Description of Accident:

_____

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Note: Patient is responsible for all fees until clinic receives approval from WCB.

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Signature Date