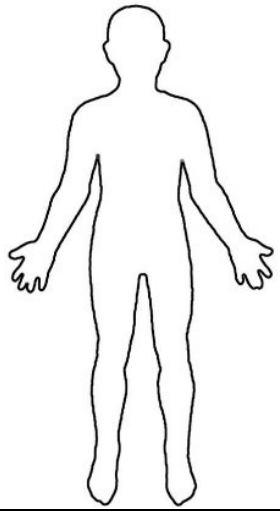
URGENT CARE By URGENT SPECIALISTS

EMPLOYER FORM – INJURY CARE PATIENT INFORMATION

Employee Name:	Date of Birth:
Injury Date:	Time of Injury:
Describe location where the injury occurred: _____ _____ _____	
How did the injury happen? _____ _____ _____	
What part of the body is injured? _____ _____	
Please check which side of the body is injured.	☐ Right ☐ Left ☐ Both
Using the figure to the right, please circle where you are injured.	
Were you seen elsewhere for this injury? ☐ Yes ☐ No If so, where?	
Name:	
Address:	
City: State: Zip:	
Phone:	