Your health. **Your Choice.** Your MRI.

WORKER'S COMPENSATION INFORMATION

Date_____

Name_____

Social Security Number_____

Date of
accident/injury_____

How did your injury occur? _____

Who was your employer at the time of injury? _____

Employer's address_____
_____

Employer's business telephone number_____

Worker's Compensation Insurance Carrier_____

Carrier's mailing address_____
_____

Carrier business telephone number_____

Adjustor_____ Claim number_____

Attorney's name, if applicable_____

Attorney's telephone number_____

4114 South Jackson Street San Angelo, Texas 76903 O: 325-703-6741 (MRI1) F: 325-703-6742
info@angelomri.com www.angelomri.com