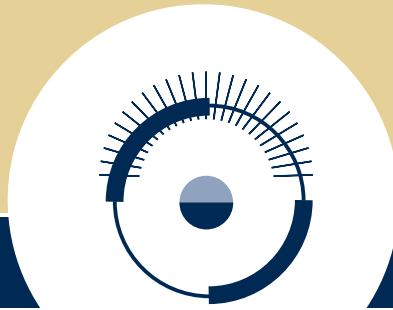


1815 State Street
Watertown, NY 13601
315.788.6070

7785 N. State Street
Lowville, NY 13367
315.376.5206



77 W. Barney Street
Gouverneur, NY 13642
315.287.3638

301 Ford Street
Ogdensburg, NY 13669
315.393.7171

WORKMAN'S COMPENSATION

TOLL FREE: 877-454-EYES

CENTER FOR SIGHT

WATERTOWN EYE CENTER

TO BE FILLED OUT BY PATIENT (Please print):

PATIENT NAME

DATE OF INJURY

How did the injury occur?: _____

Where were you when you were injured? (Street address of the location): _____

What time did the injury occur?: _____ AM / PM

Which eye or area of face was injured?: _____

Has this injury been reported to your immediate supervisor?: _____

Employer Name: _____

Employer Address: _____

Employer Phone Number: _____

Contact Person: _____

I understand that the Billing Department of Watertown Eye Center will file a claim with the New York State Workman's Compensation Board regarding my injury. They will also file claims for payment to my employer or to my employers insurance carrier. In the event this Workman's Compensation claim is disallowed for any reason, I understand that I will be responsible to pay these charges in full, and agree to do so.

PATIENT SIGNATURE

DATE

TO BE FILLED OUT BY OFFICE:

Patient Account # _____ Work Comp Carrier Name: _____

Carrier Address: _____

Carrier Phone Number: _____

Contact Person: _____

Claim Number: _____