Warren County Self-Insurance Department
1340 State Route 9, Lake George NY 12845
518-761-6528, Fax 761-6249, e-mail warrencountyinsurance@warrencountyny.gov

CC#_____

Workers' Compensation Encounter Form

To the Employee: Give one copy of this form to your physician/ chiropractor at each visit. (Call Self-Insurance for additional forms or duplicate this one.)

Patient Name:_____

Date of Service:_____ Date of Birth:_____

In your opinion, is the disability arising out of and in the course of employment or occupational disease? Yes No

Date of injury:_____

Is the patient losing time from work? Yes / No First day of lost time:___/___/___

Can the patient return to work? Full duty / Modified duty _____/ _____/_____

Modified duty requirements:_____

Diagnosis:_____

Prescriptions given to treat injury:_____

Treatment Plan:_____

Percentage of impairment (0-100%):_____% Temporary / Permanent

Apportionment? Yes No Pre-existing _____% Current injury_____%

Next visit:___/___/___ Time:_____ with Provider:_____

Providers Signature:_____ Date:____/____/____

Please Fax this form immediately to: 518-761-6249