Pre-Worksafe Visit Questionnaire

Dr. Sheila Bowling – Village Medical Clinic
Unit 1 - 9089 Glover Road
Fort Langley, BC
V1M 2S4
604-888-8300

Please print and complete this Pre-Worksafe Visit Questionnaire and bring with you to your appointment.

Patient First Name: ___________________________ **Patient Last Name:** __________________________

Date of Injury: _______________________________ **Last day of work:** ____________________________

Body Part Injured: ____

Employer/Company Name: ____

Employer's Address: ____

Employer's Phone Number: ____

What is your position or job title with the employer? ____

Briefly describe how you were injured: ____

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WCB Claim Number (If you have been assigned one already): ___________________________________