



Workers Health Centre

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Rehabilitation provider nomination form

Name:

Contact phone no. :

Injury:

Date of injury:

Claim number:

Employer:

Employer phone no. :

Insurer:

Insurer phone no. :

Union:

Union contact person:

Reason for referral to WHC:

I wish to nominate the **Workers Health Centre** as my nominated rehabilitation provider.

Signature

Print name

Date

Please complete and return fax to Workers Health Centre and provide a copy to your Employer.