AFFIDAVIT OF HEALTHCARE PROFESSIONAL PER SECTION 28-33-8(c) OF THE RHODE ISLAND WORKERS' COMPENSATION ACT

State of Rhode Island
Workers' Compensation Court
Medical Advisory Board
One Dorrance Plaza, Providence, RI 02903
Phone: 401-458-3460
TDD: 401-458-5275

◯ SIX (6) ◯ EIGHTEEN (18) ◯ THIRTY (30) ◯ OTHER _____

EMPLOYEE INFORMATION:

Social Secuity No. XXX-XX- _____
Last 4 digits only

Name: _____

Address: _____

City: _____ State: ____ Zip: _____

Phone _____ Date of Birth _____

EMPLOYER INFORMATION:

Name: _____

Address: _____

City: _____ State: ____ Zip: _____

Phone Number _____

IF THE IDENTITY OF THE INSURER IS UNKNOWN, CONTACT THE DIVISION OF WORKERS' COMPENSATION AT (401) 462-8116 FOR THE INFORMATION.

INSURANCE CARRIER:

Name: _____

Address: _____

City: _____ State: ____ Zip: _____

Phone Number _____

ADJUSTING COMPANY:

Name: _____

Address: _____

City: _____ State: ____ Zip: _____

Phone Number _____

EMPLOYEE'S INJURY INFORMATION: Injury Date _____ Incapacity Date _____

SECTION 28-33-8(b) OF THE RHODE ISLAND WORKERS' COMPENSATION ACT PROVIDES FOR A $20.00 FEE TO BE CHARGED FOR THE TIMELY FILING OF THIS FORM WITHIN ONE WEEK OF THE DUE DATE.

Current and anticipated further treatment including number of visits,frequency of visits, and type of treatment (including modalities) is as follows: (If none, so state.)

Healthcare Professional Signature _____ Lic. # _____ Date _____

Healthcare Professional Name: _____ Title: _____

Name of Facility: _____ Facility Address: _____

Subscribed and sworn to before me by the above-named healthcare professional

Print Form

MAB01-A ORIGINAL, SIGNED AND NOTARIZED - MEDICAL ADVISORY BOARD, COPY TO INSURER/SELF INSURED EMPLOYER, COPY TO PHYSICIAN'S FILE, COPY TO EMPLOYEE AND HIS/HER ATTORNEY

_____
Notary Public

My Commission Expires: _____