WORKERS' COMPENSATION BOARD OF NOVA SCOTIA

Halifax Office
5668 South Street
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336 King's Road, Suite 117
Medical Arts Building
Sydney, NS B1S 1A9
1-800-880-0003 toll free
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Chiropractic Account

05/2004

Section A Please type or print clearly, and return completed form to the WCB.

Worker name: sdfs

Claim number: sdfs

Address: _____

Date of birth (dd/mm/yyyy): _____

_____

Date of injury (dd/mm/yyyy): _____

Employer name: _____

Health card number: _____

Section B Please indicate the first and last treatment dates and type of treatment(s) used.

Date of first treatment (dd/mm/yyyy): _____

Final discharge date (dd/mm/yyyy): _____

Type of treatment:

- ☐ Chiropractic treatment
- ☐ Work conditioning
- ☐ Other: _____

Section C Please mark the treatment dates with an "x," and give the total number of visits.

Month	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31

Total visits: _____

Total appointment fees: $_____

Form fees: $_____

Total amount: $_____

Section D Please carefully read the declaration below, and sign and date the form.

I declare that the information provided above is a correct statement of the services rendered by me, and that I have received no payment (except as above stated).

_____ Chiropractor's name (Please print.)

_____ Chiropractor's signature

_____ Date

WCB use only.
Chiropractor's name_____ Contact code_____
Clinic name_____
Street_____ Telephone_____
Province/Postal Code_____ Fax_____

Payment Class: _____