Northern Orthopedic Laboratory, Inc.

Donald W. Holmes, C.P.O.
Certified Prosthetist/Orthotist

William F. Collins, C.O.
Certified Orthotist

Date:

Patient Name:
Insurance:
Insurance ID#:
Date of Service:

Ladies and Gentlemen;

I, _____ do certify that the injury sustained to my,
(patient name)
_____ on _____ WAS NOT work related.
(body part injured) (date of injury)

I injured myself: (explain HOW you injured yourself:) _____

Watertown
(Main Office)
1012 Washington Street
Watertown, NY 13601
Tel (315) 782-9079
Fax (315) 782-7545

Have you filed a claim with any worker's compensation? YES or NO

Have you filed a claim with a liability insurance/carrier? YES or NO

Have you filed a claim with a motor vehicle insurance carrier? YES or NO

Ogdensburg
500 State Street
Ogdensburg, NY 13669
Tel (315) 393-4502
Fax (315) 782-7545

By signing below, you attest that all the information given is true and that your injuries are NOT covered by ANY other insurance such as worker's compensation, motor vehicle accident, liability case, etc.

_____ _____
Signature of patient or responsible party Date

_____
Relationship to Pt.