

UNIVERSITY OF WISCONSIN-LA CROSSE

CAMPS AND CLINICS ACCIDENT CLAIM

(To Be Completed by the Injured Person)

| | |
|--|---|
| Injured Person's Full Name: | Social Security Number: |
| Street Address: | Telephone Number: |
| City, State, Zip: | Age: |
| Policy Holder's Name: UW System - Board of Regents | Physician's or Surgeon's Name: |
| Street Address: P.O. Box 8010 | Physician's Street Address: |
| City, State, Zip: Madison, WI 53708 | Physician's City, State, Zip: |
| Policy Number: 64044915 | Physician's Telephone Number: |
| Date Injured: | If Hospitalized, Name of Hospital: |
| Time Injured: AM PM | |
| When Did You Cease Work? | Hospital's Street Address: |
| If Totally Disabled, Give Dates | Hospital's City, State, Zip: |
| From: To: | |
| When Did or Will You Resume Any Part of Work? | Hospital Confinement Dates |
| | To: From: |
| Type of Camp: | |
| Describe Injuries: | |
| Describe How and Where Accident Occurred: (Attach Separate Sheet if Necessary) | |
| I hereby authorize any hospital, physician, or other person who has examined me to furnish to AON Risk Services Inc. of Wisconsin, or their representative, all information with respect to any illness or injury, medical history, consultation, prescriptions or treatment and copies of all hospital or medical records. A copy of this authorization shall be considered as effective and valid as the original. | |
| Signature: _____ | Date: _____ |

Send claims to the following:

Lisa Cheke
AON Risk Services Inc. of Wisconsin
303 E. Kilbourn Ave., Suite 450
Milwaukee, WI 53202-3179

UNIVERSITY OF WISCONSIN-LA CROSSE

CAMPS AND CLINICS ACCIDENT CLAIM PHYSICIAN'S REPORT

(To Be Completed by the Attending Physician)

| | | | | |
|--|--|--|---|----------------------------------|
| Patient's Name: | | | | |
| Nature of Injury: | | | | |
| Describe any Pre-existing condition or disease or infirmity that may or may not affect present condition: | | | | |
| Given Dates of Treatments: | Office: | | | |
| | Home: | | | |
| | Hospital: | | | |
| Is Your Patient Disabled: | Yes _____ No _____ | If yes: Total _____ Partial _____ Date _____ | Able to resume work on: _____ | Resumed work on: _____ |
| Factors Present Prolonging Disability | | | | |
| Is Patient Still Under Your Care For This Condition? | Yes _____ No _____ Contemplated Discharge Date: _____ If Discharged, Give Date: _____ | | | |
| Amount of Your Bill For Services to Date: | | | | |
| Physician's Signature _____ Date _____ | | | | |
| Street Address _____ | | | | |
| City _____ State _____ Zip _____ | | | | |
| Telephone Number (____) _____ | | | | |

Send claims to the following:

Lisa Cheke
 AON Risk Services Inc. of Wisconsin
 303 E. Kilbourn Ave., Suite 450
 Milwaukee, WI 53202-3179