A/PROF JOHN W FULLER
NEUROSURGEON
MBBS, FRACS

Workers Compensation / Third Party Declaration

Miss ☐ Ms ☐ Mr ☐ Mrs ☐

Surname _____ Given Names _____

Address _____

_____

Telephone Home _____ Work _____

Mobile _____ Email _____

Date of Birth _____ Occupation _____

Name of General Practitioner _____

Referring Doctor _____

Type of Account: Workers Compensation ☐ Third Party Claim ☐

Insurance Company _____

Address _____

_____

Date of Accident _____ Claim No _____

Employer _____

Address _____

Solicitor _____

Address _____

Declaration:

I agree to take full responsibility in settling my account in the event that it is not paid by my insurer, solicitor or employer.

Signed _____ Date _____