



Doctor / Clinic Name: _____

Doctor / Clinic Address: _____

We are sending _____ to you for an
(Employee Name)

evaluation relative to a work related injury sustained on: _____
(Date of Injury)

Please submit your Doctor's First Report of Injury and any subsequent medical reports and bills to:

CompWest Insurance Company
c/o GAB Robins North America, Inc
2310 Paseo Del Prado, Suite A-209
Las Vegas, NV 89102
Fax: (702) 892-862-8323
Telephone: (702) 892-0140

Employer Name : _____

Signature: _____

Print Name and Title: _____

Phone Number: _____

- Please be advised we make every effort to accommodate modified/light duty.
- Please be specific as to the weight, frequency and duration of those activities.