



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
6601 NE 78th Court Suite A-2
Portland, OR 97218
Fax: (503) 257-5722
Telephone: (503) 257-5170

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.**