ANNAPOLIS HAND to SHOULDER CENTER LLC

Specializing in Adult & Pediatric Upper Extremity Care

FORM COMPLETION FEE SHEET

Date: _____ Doctor: _____

Patient Name: _____ DOB: _____

Contact Phone Number: _____ Home Work Cell

Date of Injury: _____

Last Date Worked: _____

Expected Return to Work Date: _____

Injury/Body part related to paperwork: _____

Job description and restrictions requested: _____

_____

_____

_____

Date of Surgery: _____ Location: _____

Receive Completed Paperwork by:

☐ Email _____ ☐ Patient will pick up at office

☐ Fax _____ When: _____

FORM COMPLETION FEE : $25.00

Payable by cash or check and must be paid prior to release of completed Forms.

Patient Signature: _____ Date: _____

*****PLEASE NOTE, PROCESSING TIME IS 3-5 BUSINESS DAYS.*****