Saskatchewan Workers' Compensation Board

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# DOC

Click on any field to start editing.

Reset Form

**Reference or Invoice:** _____

**WCB claim number:** _____

**Name of clinic:** _____ **Provincial health number:** _____

**Clinic number:** _____ **Doctor number:** _____ **Date of birth:** _____ MM/DD/YYYY

**Phone:** _____ **Fax:** _____

*Physician's name, address, postal code*

*Worker's name, address, postal code*

**Date of injury:** _____ MM/DD/YYYY **Off work** ☐ **Yes** ☐ **No**

**Part of body:** _____

**Diagnosis:** _____

**Referral from Dr.:** _____

**Employer name:** _____

| Treatment date MM/DD/YYYY | Fee descriptor | Fee code | Number of units | Est. cost |
|---|---|---|---|---|
| | | | | |
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| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | Total | |

**Comments:** _____

* indicates the fee amount has been overridden.
This invoice is subject to WCB review