WC INSURANCE INFORMATION

NAME OF PATIENT: SHAQUAN ROLLAING

DATE OF BIRTH: 01/24/1978

SSN: XXX-XX-8672

ADDRESS: 2475 SOUTHERN BOULEVARD, APT. 9L, BRONX, NY 10458

TELEPHONE: 347-468-5251

EMPLOYER AT TIME OF ACCIDENT: RANDALL'S ISLAND PARK ALLIANCE

ADDRESS: 24 WEST 61ST STREET 4TH FLOOR, NEW YORK, NY

Tel. 212-830-7722

INSURANCE CARRIER: NYSIF

ADDRESS: 199 CHURCH STREET, NEW YORK, NY 10007

WCB number: G3065668

CARRIER CASE: 73208761-364

DATE OF INJURY: 07/23/2021

Case Manager: GEORGE DAVIS (GDAVI2@nysif.com)

Tel. 212-587-2324

Fax 212-587-7395

**Ketan D. Vora, DO, P.C.**
68-60 Austin St., STE 404
Forest Hills, NY 11375
Tel #: 1-877-SPINE-DR
Fax: (347) 708-8499

## WC Forms

Date: 7/15/20

I, Shaquan Rollins, hereby authorize **Ketan D. Vora, PC** to use my signature as signed below for the following documents:

1. Workers Compensation Board form
2. Employee Claim, C-3 form
3. Workers Compensation release form, C-3.3
4. Consent to use and Disclosure of Health Information form
5. Informed Consent form
6. Fee Guarantee Agreement
7. HIPAA (OCA official Form N0.: 960)

(Please sign in the middle of the box with a black pen)