MC MUTUAL

Register of entry at MC MUTUAL

REQUEST FOR MEDICAL CARE

Information on the Workplace (to be filled in by the Company's manager or representative)

Company: ____ Tax ID Number (NIF in Spanish): ____________________________

Workplace: _________________________________ Social Security Account (CCC in Spanish):___________________________________

Phone: ____________________________________

Information on the Worker (to be filled in by the Company's manager or representative)

Full Name:____

ID NUMBER: _______________________________ Work Position_____________________________

Phone: ____________________________________ Regular Schedule ________________________

MARK THE APPROPRIATE SELECTION WITH AN X:

☐ The event was directly observed by the company's manager or by another co-worker.

☐ The cited worker has experienced an INCIDENT that could not be verified by the company.

Description of the INCIDENT (to be filled in by the Company's manager or representative)

Date of INCIDENT:_____________ Time of INCIDENT:______________________________

Exact location:____

Manner in which the Incident took place – **Detailed description:**

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Indicate the name and National ID Number (DNI) of the witnesses, if there are any:

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Information on the Company's manager or representative filling in the referral form

Full Name:____

ID NUMBER: ________________________________

Signature and stamp: Date:

Issuance of this request for medical care does not imply acknowledgement of the professional contingency by this mutual society.

It is recommended that the company should save a copy of this document.

Mutual Midat Cyclops, Collaborative Mutual Society with the Social Security Institute **number 1**.