ADDRESS LINE 1
ADDRESS LINE 2
ADDRESS LINE3

WC CLAIM NO:	9999-999999	IF YOU CALL OR WRITE US
INJURY DATE:	05/01/85	PLEASE USE WC CLAIM NO.
EMPLOYEE:	SAMPLE-SIMPLES, SAMPLE	
EMPLOYER:	SAMPLE EMPLOYER INC	
INSURER NO:		

Dear Dr. Example:

The insurer listed below informed us that they did not receive your medical report on the treatment and present condition of the injured employee.

Please complete the enclosed Medical Report on Industrial Injury, form WKC-16, and send it to the insurer at the address given below. If it is too early for a final report, please give the present condition and the approximate date a final report can be expected.

A medical report is necessary to ensure prompt and full payment of compensation benefits and medical bills.

Your cooperation is appreciated.

Sincerely,

Department of Workforce Development
Worker's Compensation Division

GL15 (R. 07/2003)

LastFirstALJintGL15

Enc. w/original: 1 WKC-16 Form

Copy sent to:
TEST INSURER 2
C/O TEST INSURER 2
RM C100
201 E WASHINGTON AVE
MADISON WI 53703