ATTENDING PHYSICIAN WORK RELATED INJURY EVALUATION

This is a work-related injury.

PROVIDE TO EMPLOYEE TO GIVE TO TREATING FACILITY

Client Company:			
Injured Worker:		D.O.B.	
Address:		Phone Number:	
Date of Injury:			

√ A post-accident drug screening is required for this incident

- Please collect an urine sample for testing
- It is the client's responsibility to pay for this screening

Release of Medical Information: I certify that the above information is true an correct to the best of my knowledge and I authorize the release to my employer and workers' compensation company all records relevant to my disability and my claim for disability or workers' compensation benefits, including but not limited to medical diagnosis, prognosis, treatment, and periods of hospitalization. It is understood that the company will use the information to verify my disability and determine my eligibility of appropiate benefits. This authorization applies to physicians and other health care providers, hospitals, clinics, insurance companies, workers' compensation carriers, and organizations administering benefit programs. This authorization will remain in effect throughout my claim for workers' compensation benefits. A photocopy of this authorization will be as valid as the original. I have been informed that a post-accident drug screening will be required in the event that my injury/illness causes me to seek or obtain medical treatment. I agree to comply with the post-accident drug screen and release the results to my employer and workers' compensation company for use in the evaluation and determination and administration of my claim.

Employee Signature		Date:	

Diagnosis/Condition:

I saw and treated this patient on ( ) and based upon the above description of the patient's current medical problem:
○ I recommend his/her return to work on ( ) with no limitations
○ She/he may return to work on ( ) with the following restrcitions: (Please describe):
○ I recommend he/she see his/her physician/specialist for additional evaluation.
Treating Physician's Signature: Date:

Facility Name:	
Address:	
Phone:	

PLEASE PROVIDE A COMPLETED COPY TO RETURN TO EMPLOYER