Medical Treatment Authorization

Work Status Report—Employee Accidents

TREATMENT AUTHORIZATION ***To be completed by Supervisor or District Contact:***	**District Name:** **District Address:** **Phone**: **Fax:**	
Employee:	Site Phone Number:	Employee Job Title:
Date of Injury:	Type of Injury or Illness:	
Treatment Authorized By:	Date:	
Designated Medical Facility for Treatment:		
RETURN TO WORK STATUS ***To be completed by Physician:***	Light duty is usually available to employees who are released by a physician with limitations that permit them to be productive and to work without undue risk of aggravation or re-injury.	
Diagnosis:		
Treatment:		
Is Treatment Complete? ☐ Yes ☐ No	Date and time of Next Appointment:	

RESTRICTIONS:

- ☐ Return to Regular Duties (no restrictions) on:
- ☐ Unable to Return to Work Until:
- ☐ Return to Work on:_____
  With the following restrictions:
  - ☐ No lifting over 15 25 35 50 pounds
  - ☐ Keep the injured area clean and dry
  - ☐ Limit use of affected body parts
  - ☐ Other *(please be specific what employee **can** and **cannot** do:*

Expected Duration of Restrictions:	
Special Instructions/Remarks:	
Medical Facility: Name: Address: Phone Number:	Physician Signature: Date of Treatment:

Clinics: Send billing directly to Acclamation Insurance Management Services (AIMS)

PO Box 269120, Sacramento, CA 95826