

# TREATMENT AUTHORIZATION/WORK STATUS REPORT

## EMPLOYEE ACCIDENTS

<b>TREATMENT AUTHORIZATION</b> <i>To be completed by Supervisor or District Contact:</i>		District: <b>FOLSOM-CORDOVA UNIFIED SCHOOL DISTRICT</b>	
Employee:		School Location:	
Date of Injury:		Site Phone Number:	Job Title:
Treatment Authorized By:		Type of Injury or Illness:	
Designated Medical Facility for Treatment:		Date:	
<b>RETURN TO WORK STATUS</b> <i>To be completed by Physician:</i>		Light duty is 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 reinjury.	
Diagnosis:			
Treatment:			
Is Treatment Complete? <input type="checkbox"/> Yes <input type="checkbox"/> No      Date and time of Next Appointment:			
<input type="checkbox"/> Return to Regular Duties (no restrictions) on: <input type="checkbox"/> Unable to Return to Work Until: <input type="checkbox"/> Return to Work on:      With the following restrictions: <ul style="list-style-type: none"> <li><input type="checkbox"/> No lifting over 15      25      35      50      pounds</li> <li><input type="checkbox"/> Keep the injured area clean and dry</li> <li><input type="checkbox"/> Limit use of affected body parts</li> <li><input type="checkbox"/> Other (please be specific what employee <i>can</i> and <i>cannot</i> do:</li> </ul>			
Restrictions:			
Expected duration of Restrictions:			
Special Instructions/Remarks:			
<b>Medical Facility</b> ( <i>Stamp all Copies</i> ) Name:		Physician Signature:	
Address:		Date of Treatment:	
Phone Number:			

**Billing and copy of form should be sent to:**

**Gregory B. Bragg & Associates.**  
PO Box 619058  
Roseville CA 95678-9058

**Fax Copy to District Office**