

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 York Insurance Services Group, Inc., PO Box 619058, Roseville CA 95661