Norfolk Public Schools
NATIONALLY RECOGNIZED. GLOBALLY COMPETITIVE.

AUTHORIZATION FOR MEDICAL CARE FORM
Workers' Compensation Employee Injury Status Report

I, _____ sustained an injury to my _____
Print Full Name **Body Part(s)**
in an occupational accident dated _____ while performing my duties as a _____
Month/Day/Year **Occupational Title**
at _____. I have been provided by my immediate supervisor or his/her
School/ Facility/Department
designee with a panel of treatment facilities. From the list I have chosen to go to _____
(Medical Care Facility)

*** _____ _____ ***
Date **Employee's Signature**

Dear Attending Physician or Treating Facility:
The above-named employee has alleged an injury/illness arising out of and during the course of his/her employment with the Norfolk City School Board. All compensable claims for injuries incurred before September 1, 2009, will be satisfied by Norfolk Public Schools. Please examine the employee and provide necessary medical care so as to achieve the earliest return to work date. Upon completion of your treatment, an itemized statement of charges and findings must be submitted to:

NORFOLK CITY SCHOOL BOARD * RISK MANAGEMENT & SAFETY * P. O. BOX 1357 * NORFOLK, VA 23501

All treatment, itemized statement of charges and findings for injuries that occur after September 1, 2009 must be submitted to:

SEDGWICK CMS * P. O. BOX 14663 * LEXINGTON, KY 40512-4663

Should you encounter any problems, please contact the Insurance Claims Technician or Senior Director of Risk Management at 628-3856. Your anticipated cooperation in this regard will be most appreciated by our employee and the School Board.

_____
Signature, Referring Supervisor

PHYSICIAN'S REPORT -- EVERY EFFORT WILL BE MADE TO ACCOMMODATE MODIFIED DUTY

REPORT OF PHYSICIAN:
Nature of Injury/Condition: _____

RELEASE STATUS:
Full Duty _____ Projected Date of Full Duty Return to Work _____
No Duty _____ Next Appointment Date _____
Modified Duty _____ Next Appointment Date _____

PHYSICAL CAPACITIES:
Please circle YES/NO, as appropriate. Indicate hour(s) per day allowed as needed.

Task	Status		Number of Hours Per Day
Standing	Yes	No	_____
Pushing/Pulling	Yes	No	_____
Sitting	Yes	No	_____
Use of Hands	Yes	No	_____
Lifting	Yes	No	_____
Stooping/Bending	Yes	No	_____
Walking	Yes	No	_____
Reaching	Yes	No	_____
Climbing Stairs/Ladders	Yes	No	_____
Operation of Commercial Vehicle/Equip. for Work	Yes	No	_____

Referred for Additional Medical Care to: _____
PHYSICIAN'S COMMENTS: _____
_____

Physician's Signature: _____ **Date:** _____