CITY OF HIALEAH

WORKMAN'S COMPENSATION MEDICAL AUTHORIZATION

Hospital/Emergency Room, Clinic or Urgent Care: _____

Address of Location: _____

_____	_____	_____	_____
Name of Employee	**Job Title**	**Date of Injury**	**Time**

Nature of Occurrence: _____

_____	_____	_____	_____
Department Head/Supervisor	**Title**	**Date**	**Time**

_____

MEDICAL USE ONLY

Description of injury/Illness: _____

_____

Hospitalization Admission: _____ Yes or _____ No.

Treated and Release to work: _____ OOW _____ Light Duty or _____ Full Duty

If is Light Duty what restrictions: _____

Future Treatment, if yes: Specify treatment plan and next office visit_____

_____

Referral to another Physician: _____ Yes or ____ No. If yes what specialty**: _____**

_____	_____	_____
Physician Signature	**Title**	**Date**

RETURN TO DEPARTMENT HEAD/SUPERVISOR AND RISK MANAGEMENT VIA EMPLOYEE.

Note to Physician:

The City desires to provide limited work for those employees who are injured and are capable of doing jobs other than their normally assigned work. It is requested that the physicians specify in as much detail as possible, the work restrictions of an injured employee to perform other work. The more specific the physician's comments the better the City can provide duties for the employee commensurate with limitations.

ALL MEDICAL BILLS NEED TO BE SUBMITTED TO:
SEDGWICK CLAIMS MANAGEMENT SERVICES, INC.
P.O.BOX 14511
LEXINGTON, KY 40512-4511