CITY OF HIALEAH

FIRE DEPARTMENT, 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:

Full Work Status for Firefighters is defined as: the ability to perform firefighting functions such as but not limited to: Wearing firefighting protective ensemble weighing at least 50lbs., advancing hose lines, increased respiratory workload, high-temperature environments, climbing stairs with equipment, carrying or dragging victims or heavy equipment.

FORWARD THROUGH THE CHAIN OF COMMAND TO FIRE ADMINISTRATION IMMEDIATELY. THIS FORM MUST BE COMPLETED EVERY TIME THE EMPLOYEE IS SEEN BY A PHYSICIAN.

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