

**ATTENDING PHYSICIAN WORK RELATED INJURY EVALUATION**

**This is a work-related injury.**

**PROVIDE TO EMPLOYEE TO GIVE TO TREATING FACILITY**

Client Company:	
Injured Worker:	D.O.B.
Address:	Phone Number:
Date of Injury:	

**✓ A post-accident drug screening is required for this incident.**

- Please collect a urine sample for testing.
- It is the client's responsibility to pay for this screening.

**Release of Medical Information:** *I certify that the above information is true to the best of my knowledge and I authorize the release to my employer and workers' compensation company all records relevant to my disability and my claim for disability or workers' compensation benefits, including but not limited to medical diagnosis, prognosis, treatment, and periods of hospitalization. It is understood that the company will use the information to verify my disability and determine my eligibility of appropriate benefits. This authorization applies to physicians and other health care providers, hospitals, clinics, insurance companies, workers' compensation carriers, and organizations administering benefit programs. This authorization will remain in effect throughout my claim for workers' compensation benefits. A photocopy of this authorization will be as valid as the original. I have been informed that a post-accident drug screening will be required in the event that my injury/illness causes me to seek or obtain medical treatment. I agree to comply with the post-accident drug screen and release the results to my employer and worker's compensation company for use in the evaluation and determination and administration of my claim.*

Employee Signature:	Date:
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<u>Diagnosis/Condition:</u>
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I saw and treated this patient on ( ) and based upon the above description of the patient's current medical problem:	
<input type="radio"/> I recommend his/her return to work on ( ) with no limitations.	
<input type="radio"/> She/he may return to work on ( ) with the following restrictions: (Please describe.):	
<input type="radio"/> I recommend he/she see his/her physician/specialist for additional evaluation.	
Treating Physician's Signature:	Date:
Facility Name:	
Address:	
Phone:	

**PLEASE PROVIDE A COMPLETED COPY TO RETURN TO EMPLOYER.**

Forward a copy to:

FORTUNE BUSINESS SOLUTIONS

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