AppleCare Work Comp/Work Status/Employee Acknowledgment

Workers Compensation Claims: To be filled out by Employer

Please complete for all workers compensation claims. If claim number is not available, patients social security number must be used.

Employee Name _____ DOB _____

Employer Name _____ Authorizing Signature _____

Employer Address _____ Employer Phone _____

Fax Work Status To _____ Fax Number _____

Has employer filed a First Report of Injury? ☐ Yes ☐ No (send/attach copy if available)

Work Comp Insurance Carrier (If carrier information is not available employer is responsible for payment of claim)

Carrier _____ WC Claim # or SS# _____

Address _____ City _____ State _____ Zip _____

Date of Injury_____ Time of Injury _____ Injury Site (example: arm, leg, elbow)_____

Authorized to Dispense Meds ☐ YES ☐ NO

Work Comp Drug Screen: ☐ 5 Panel Send Out ☐ 5 Panel Instant ☐ 10 Panel SendOut ☐ 10 Panel Instant ☐ Escreen

See Occupational Authorization for more detailed drug testing

Workers Compensation Work Status: To be filled out by AppleCare Team Member

Employee Name _____ Injury Site: _____ Injury Date: _____

RTW FULL DUTY ON ___/____/____ CONTINUE FULL DUTY AS OF TODAY _____YES _____NO

RETURN TO WORK WITH THE FOLLOWING RESTRICTIONS:

❑ NO LIFTING OVER_____ POUNDS WITH _____RT_____LT UPPER EXTREMITY

❑ NO PROLONGED STANDING/WALKING _____(acceptable limit per physician)

❑ NO PUSHING ❑ NO PULLING ❑ NO OVERHEAD WORK

❑ NO CLIMBING ❑ NO STOOPING ❑ NO KNEELING

❑ NO SQUATTING ❑NO BENDING ❑NO TWISTING

NO USE OF: RIGHT _____/LEFT _____/_____

DIAGNOSIS: _____

_____

NOTES: _____

_____

REQUESTING AUTHORIZATION FOR: MRI _____ CT _____ REFERRAL TO: _____

FOLLOW UP APPT: _____

HAVE PAIN MEDICATIONS BEEN PRESCRIBED TO PATIENT? _____YES _____ NO

PATIENT IS AWARE OF RESTRICTION ALONG WITH NO DRIVING, USE OF MACHINERY, OR DECISION MAKING WITHIN SIX (6) HOURS OF TAKING PAIN MEDICATIONS

TREATING PHYSICIAN SIGNATURE:_____DATE:_____

*** PLEASE SEE OFFICE NOTE FOR FULL DETAILS***