PRINT FORM

CLEAR FORM

City of Newport News
Employee's Notice of Injury/Disease
Authorization for Medical Treatment Form

(Revised: Aug 2017)

TO BE COMPLETED BY INJURED EMPLOYEE

Name: _____ Employee ID No.: _____ Phone No.: _____

Home Address: _____ City: _____ State: _____ Zip Code: _____

Dept./Division: _____ Position: _____

Work Address: _____

Date of Injury/Disease Diagnosis: _____ Time of Injury: _____ ☐AM ☐PM Time Began Work: _____ ☐AM ☐PM

Address Where Injury Took Place: _____

Clearly describe how injury/disease occurred to include specific body parts injured:

_____

_____

_____

As allowed by Section 65.2-603 of the Virginia Workers' Compensation Act, one of the following physicians must be selected for each injury for treatment needed now, **and/or may be needed in the future. Failure to choose and treat with one of the physicians from the panel can result in a suspension of medical and lost wage benefits.**

***If you are exposed to a bloodborne pathogen or other infectious disease, please seek treatment at Mary Immaculate OccuMed. If you are subsequently diagnosed with an infectious disease as a result of the exposure, you may choose another panel physician at that time.**

I choose _____ as my authorized treating physician for this injury.

Dr. Michael Baddar I & O Medical Center 593 Aberdeen Road Hampton, VA 23661 (757) 825-1100	Dr. Michael Baddar I& O Medical Center 704 Thimble Shoals Blvd. #200 Newport News, VA 23606 (757) 240-5580	Dr. Roxanne Dietzler 732 Thimble Shoals Blvd. #102 Newport News, VA 23606 (757) 599-3623	Dr. Krishna Padiyar Mary Immaculate OccuMed 14703 Warwick Blvd. Newport News, VA 23608 (757) 886-6633 *INFECTIOUS DISEASE EXPOSURES	Dr. Anthony Cetrone NowCare I 6632 Indian River Road Virginia Beach, VA 23464 (757) 424-4300

I confirm that the information I have provided is true and correct and that I have received a Workers' Compensation a Questions & Answers Brochure from the City of Newport News dated Feb 2018.

_____ (Employee's Signature) _____ (Date)

TO BE COMPLETED BY INJURED WORKERS SUPERVISOR

The employee reported this injury to me on the following date: _____

(Check one)

☐ Employee is NOT seeking medical treatment at this time.

☐ Employee is seeking medical treatment with the physician selected.

☐ Transported to the following Emergency Department: _____ (Facility Name) ☐ By Ambulance

I confirm that I have provided the above injured worker with a Workers' Compensation Questions & Answers Brochure from the City of Newport News dated Feb 2018.

_____ (Supervisor's Signature) _____ (Date)

TREATING PHYSICIAN

I have examined this employee and diagnosed him/her with: _____

☐ He/She has been released to full duty effective: _____

☐ He/She is to stay out of work effective: _____ through _____

☐ He/She has been instructed to return and see me on the following date: _____

☐ He/She has been referred to see Doctor: _____ (for additional medical care)

☐ He/She has been referred to physical therapy effective: _____

☐ He/She may work with the following restrictions effective: _____ through _____

_____

_____

_____

_____ (Physician's Signature) _____ (Date)

After completion by the physician, the employee should return this form to their supervisor.