



City of Newport News
Employee's Notice of Injury/Disease
Authorization for Medical Treatment Form
 (Revised: April 2020)

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 <u>Mon-Fri:</u> 7:30 am-7:30 pm <u>Sat & Sun:</u> 9:00 am- 2:30 pm	Dr. Michael Baddar I & O Medical Center 704 Thimble Shoals Blvd. #200 Newport News, VA 23606 (757) 240-5580 <u>Mon-Fri:</u> 8:00 am-6:00 pm <u>Sat:</u> 9:00 am- 1:00 pm <u>Sunday:</u> Closed	Dr. Roxanne Dietzler 732 Thimble Shoals Blvd. #102 Newport News, VA 23606 (757) 599-3623 <u>Mon-Fri:</u> 7:00 am-3:30 pm <u>Saturday & Sunday:</u> Closed	Dr. Krishna Padiyar Mary Immaculate OccuMed 14703 Warwick Blvd. Newport News, VA 23608 (757) 886-6633 *INFECTIOUS DISEASE EXPOSURES <u>Mon-Fri:</u> 8:00 am-4:30pm <u>Saturday & Sunday:</u> Closed	Dr. Anthony Cetrone NowCare I 6632 Indian River Road Virginia Beach, VA 23464 (757) 424-4300 <u>Mon-Fri:</u> 8:00 am-8:00 pm <u>Sat & Sun:</u> 9:00 am- 3:00 pm

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 July 2020.

 (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: _____ By Ambulance
 (Facility Name)

I confirm that I have provided the above injured worker with a Workers' Compensation Questions & Answers Brochure from the City of Newport News dated July 2020.

 (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.