Florida College System Risk Management Consortium

WORKER'S COMPENSATION MEDICAL REPORT

TO EMPLOYEE: You have reported a work-related injury and are being directed to a physician for care. All medical care associated with your work injury must be authorized prior to receiving treatment. Please provide this form to the physician and wait for it to be completed. It must be returned to your work location administrator the next work day. If you do not feel medical care is needed at this time, please contact us immediately in the event treatment is needed, and an authorized physician will be provided for you. Kindly acknowledge receipt by signing below.

_____ _____

Signature of Acknowledgement ***Date***

Employee's Name:	Date of Accident:
Employee No.:	Employee's Social Security No.:
Address:	Telephone No.:
Work Location:	Position:
Physician's Name:	Address:
Description of Accident:	Part of Body affected:
Authorized by:	Title: Date:

(Signature of Employer)

TO PHYSICIAN:

1. This authorization is for <u>INITIAL MEDICAL TREATMENT ONLY</u>. If additional treatment or prescriptions are indicated, please contact Johns Eastern Company at 800-749-3044. Continued treatment without authorization will result in non-payment of additional medical bills.
2. Pursuant to Florida Statute, Chapter 440, FCCRMC reserves the right, under certain circumstances, to conduct appropriate drug and alcohol testing.
3. Please complete reports as required by Florida Worker's Compensation Statute. Send medical bills and reports to:

Johns Eastern Company
PO Box 110279
Lakewood Ranch, FL 34211-0004

Diagnosis:	
Treatment Rendered:	
Date of Visit:	Date Able to Resume Work: ☐ Full Duty ☐ Restricted
Current Restrictions/Limitations:	
Physician's Signature:	
Attending Physician's Name:	
Address:	Telephone No.: