

MEDICAL REFERRAL

DISTRICT TO COMPLETE THIS SECTION:

DATE _____

EMPLOYEE'S NAME _____ DISTRICT _____

ADDRESS _____ DEPARTMENT _____

PHONE _____

HAS IDENTIFIED _____
(MEDICAL PROVIDER)

(AUTHORIZED FOR THE DISTRICT)

MEDICAL PROVIDER:

Our Workers' Compensation program is self-insured. Please report your findings to _____ District and Keenan & Associates
2105 S. Bascom Ave. Suite 310
Campbell, Ca. 95008

for consideration of workers' compensation eligibility. Alternative insurance sources may be available for non-work related conditions.

If you have any questions or wish to discuss the medical problem, course of treatment or specialist referral, please call 408-377-3338 for direct contact with our Workers' Compensation claims examiner _____.

RETURN TO WORK AUTHORIZATION

MEDICAL PROVIDER:

If patient is able to return to work today or tomorrow, please show date and time below, sign and give to patient to return to employer.

RETURN TO WORK _____
(Date - Time)

IF PATIENT IS UNABLE TO RETURN TO WORK TODAY OR TOMORROW, PLEASE INDICATE ESTIMATED RETURN DATE _____

IF PATIENT IS ABLE TO RETURN TO WORK WITH RESTRICTIONS, PLEASE INDICATE WORK RESTRICTIONS BELOW (Be Specific)

BY _____
Doctor

Address _____

INJURED WORKER:

PLEASE RETURN THIS AUTHORIZATION TO YOUR EMPLOYER TODAY

DISTRIBUTION: White • District/Supervisor, Yellow • Medical Provider, Pink • District Diary Control
5/2/77-88 1. SANTA CRUZ/SAN BENITO COUNTY SCHOOLS INSURANCE GROUP