NC STATE UNIVERSITY WORKERS' COMPENSATION
MEDICAL AUTHORIZATION AND ATTENDING PHYSICIAN'S REPORT

SUPERVISOR (please complete)

Name of Employee/Patient – Last:	First:
Date of Injury:	Social Security Number:
Name of Employer/Company: NC State University	Workers' Compensation Coordinator: 919/ 515-2151
Supervisor Name (please print)	Supervisors phone #:
Supervisor/Employer Signature:	Type of Injury:
☐ Rx Urgent Care 3100 Blue Ridge Road Raleigh, NC 919/ 719-2250 **Hours:** **M-F 8 am – 8 pm** **Sat. 8 am – 6 pm** **Sun. 10 am – 2 pm**	☐ Doctor's Urgent Care Center 801 Highway 70 West Garner, NC 919/ 779-5010 **Hours:** **M-Sat 8 am – 8 pm** **Sun. 12 pm 6 pm**
☐ Doctor's Urgent Care Center 1110 Kildaire Farm Road Cary, NC 919/ 481-0277 **Hours:** **M-Sat. 8 am – 8 pm** **Sun. 12 pm 6 pm**	☐ **PostDoc/Student workers only** Student Health Services 2815 Cates Avenue 919/513-2563 919/513-2519 Fax **Hours:** **M-W-Th-Fri 8 am – 9 pm** **Tue. 9 am – 9 pm** **Sat . 830 am – 1130 am**
For NC State Departments outside the Raleigh area, contact the CompCare Network for an authorized physician at 1-800-605-7320 or the Workers' Compensation Coordinator <u>and</u> record the physician information below: _____ **<u>Post Docs/Student workers</u> must be sent to Student Health Services during their hours operation listed above.**	

PHARMACY: Process all prescriptions on-line through ***TMESYS*** for this patient by contacting them at 1-800-964-2531 to establish eligibility **<u>PRIOR</u>** to processing on-line.

AUTHORIZED PHYSICIAN (please complete):

_____ has been treated today for _____.

A post accident drug test (check one) ☐ has or ☐ has not been completed.

In accordance with this patient's physical capability, check all that apply:

☐ May resume work immediately, no restrictions.

☐ May resume work immediately with the following restrictions ***(NCSU will attempt to work within restrictions set by physician)*:**

- ☐ Sedentary work (sitting, occasional walking, standing, lifting less than 10 lbs.)
- ☐ Light work (lifting less than 20 lbs.)
- ☐ Medium work (lifting less than 50 lbs.)
- ☐ Heavy work (lifting less than 100 lbs.)

☐ He/she is released to work:

- ☐ _____ hours per day
- ☐ His/her normal shift

***Please include additional comments on a separate sheet.**

☐ Repetitive Motion Restrictions

Frequency	Left _____	Right _____
Occasional <33% of time		
Frequent 34-66% of time		
Constant 67-100% of time		

☐ He/she may return to work at full duty on (date) _____

☐ He/she has a return appointment on (date) _____ at (time) _____

Please indicate any referrals that are required: _____

_____	_____	_____
Physician's Signature	**Date**	**Physician's Name (type or print)**

Note: Please provide the patient a copy of this form.

Be sure to contact the KRMS claims department to gain authorization for the referral. Contact Key Risk Management Services, Inc. for referral, authorization, pre-certification, or if billing questions arise.

KEY RISK MANAGEMENT SERVICES, INC. * PO BOX 49129 * GREENSBORO, NC 27419 * 1-800-942-0225

REV. 4/2005