Treatment to be provided by:

Medical Treatment Referral
(To be completed by Supervisor)

Fax to Risk Management at 704-632-8410

Bills should be sent to:
City of Charlotte/Risk Management, 301 S. McDowell St, Ste 1100, Charlotte, NC 28204-2640 Main Workers' Comp # 704-336-3021

Employer: City of Charlotte ☐ Mecklenburg County ☐ Charlotte-Mecklenburg Schools ☐ MEDIC-EMS Agency ☐ CRVA ☐

Name of Employee:____________________ Employee No.:________ Department: ____________

Job Title:____________________ Department: ________________

Date of Injury:____________ Time of Accident:__________ Date Accident Reported:____________

Who witnessed the accident? ________________________ Vehicle Accident? *Yes* ☐ *No* ☐

Post-Accident Drug and Alcohol Screening *Yes* ☐ *No* ☐

Was he/she working at their regular job at the time of the accident?____________________

Is medical attention required? *Yes* ☐ *No* ☐ Emergency: *Yes* ☐ *No* ☐ Accident location:______________

Has previous treatment been received for this injury: *Yes* ☐ *No* ☐ Where:____________________

Describe Incident and Injury:____________________________________

____

____

____

I believe this event is job related and recommend that this individual seek initial medical care.

Supervisor's Signature____________________Job Title______________Date________

Supervisor's printed name:____________________Contact number:______________

Prescriptions and Driving

<u>To be filled out by the Physician</u>

Prescription Written/Received? *Yes* ☐ *No* ☐

Can the employee safely return to work, while taking this medication? *Yes* ☐ *No* ☐

For Driving Positions: Can the employee currently drive back and forth to work? *Yes* ☐ *No* ☐

Can the employee currently perform his/her driving position? *Yes* ☐ *No* ☐

Physician's Signature Date