- **AUTHORIZATION TO PHYSICIAN**
- **MEDICAL TREATMENT REPORT**
- **RETURN TO WORK**

1. ACCIDENT REPORT

EMPLOYEE NAME: _____ ACCIDENT DATE: _____

EMPLOYER / DEPT: _____ TIME: _____

ACCIDENT DESCRIPTION: _____

2. AUTHORIZATION TO PHYSICIAN

The above named individual has reported an injury sustained on the job to his/her supervisor during working hours. He/she has been authorized to seek a medical opinion regarding this injury from:

- ☐ **Emergency Room: Indian River Medical Center:** 1000 36th Street, Vero Beach – 567-4311
- ☐ **Emergency Room: Sebastian River Medical Center:** 13695 US Hwy 1, Vero Beach – 589-3186
- ☐ **Care Spot Urgent Care**: 1820 58th Ave., Vero Beach – 772-257-3200
- ☐ **Indian River Walk-In Care**: 1880 37th St, Suite 4, Vero Beach – 772-778-1400 (Call first for appointment)
- ☐ **MD Now (IR Walk-In Clinic)**: 640 21st St, Vero Beach – 772-299-1092
- ☐ **IRMC Walk-In Sebastian**: 801 Wellness Way, Suite 107, Sebastian – 772-226-4200
- ☐ **MedExpress Urgent Care:** 1150 US Hwy 1, Vero Beach – 772-978-5679

Employer: Indian River County, Attn: Risk Mgmt., 1800 27th St., Vero Beach, FL 32960 ● (772) 567-8000 ext. 1292

Claims/Billing: Johns Eastern Company, P.O. Box 110279, Lakewood Ranch, FL 34211 ● (800) 749-3044

3. MEDICAL TREATMENT REPORT

***** **Treating Physician: Please complete DWC25 or this form and return to the employee.** *****

Treatment Date: _____ Diagnosis: _____

- ☐ Call for recheck. Next appt date/time: _____
- ☐ No further treatment necessary.
- ☐ Patient Referred To: _____
- ☐ Other:

4. RETURN TO WORK

PLEASE NOTE: In the event an employee cannot return to work in their regular assigned position, Indian River Co. will make every attempt to find alternative work (answering phones, directing traffic, filing, greeting the public) within the restrictions to return the employee back to work.

- ☐ Patient may return to work full duty. ☐ Patient may not return to work until: _____
- ☐ Patient may return to work with the following restrictions effective until: _____

☐ NO:
- ☐ USE OF RIGHT UPPER EXTREMITY
- ☐ USE OF LEFT UPPER EXTREMITY
- ☐ USE OF RIGHT HAND
- ☐ USE OF LEFT HAND
- ☐ PUSHING
- ☐ PULLING
- ☐ PROLONGED STANDING
- ☐ REPETITIVE BENDING

☐ NO EXCESSIVE:
- ☐ REPETITIVE LIFTING
- ☐ LIFTING
- ☐ LIFTING OVER _____ POUNDS
- ☐ BEARING WEIGHT ON LEFT FOOT
- ☐ BEARING WEIGHT ON RIGHT FOOT
- ☐ MONOCULAR VISION
- ☐ SQUATTING
- ☐ CLIMBING

OTHER: _____

PHYSICIANS' SIGNATURE DATE

Instructions: 1) Supervisor/Employee: Complete section 1-2 / Employee take form to Dr
2) Doctor: Return DWC25 or this form (Section3-4) to employee after office visit
3) Supervisor: Copy Risk Mgmt.