OCEANSIDE UNIFIED • SCHOOL • DISTRICT

WORKERS' COMPENSATION/ RETURN TO WORK OFFICE
2111 MISSION AVENUE, OCEANSIDE, CA 92058-2326
PHONE: 760-966-4035 FAX: 760-967-7178

AUTHORIZATION FOR MEDICAL TREATMENT

WORK-RELATED EMPLOYEE INJURY

EMPLOYEE NAME: ______________________________

JOB TITLE: ____________________ EMPLOYMENT SITE: ____________________

DATE OF INJURY: ____________________ TIME OF INJURY: ____________ ☐ AM ☐ PM

PLEASE CHOOSE AN OPTION BELOW:

☐ **I ACCEPT** MEDICAL TREATMENT.
COMPANY NURSE CONTACTED? ☐ YES ☐ NO
IF INSTRUCTED BY THE COMPANY NURSE, PROCEED TO THE MEDICAL PROVIDER SELECTED BELOW.

☐ **I DECLINE** MEDICAL TREATMENT AT THIS TIME. ADDITIONALLY, I UNDERSTAND THAT IF I SHOULD NEED MEDICAL TREATMENT AT A LATER DATE, I WILL NOTIFY MY SUPERVISOR & THE WORKERS' COMPENSATION DEPT.

NOTE: MEDICAL EXAMINATIONS OUTSIDE OF THE PROVIDERS LISTED BELOW MAY RESULT IN CLAIM & TREATMENT DELAYS

√	MEDICAL PROVIDER	ADDRESS	PHONE	HOURS
☐	WORKPARTNERS OCCUPATIONAL HEALTH SPECIALISTS	3156 VISTA WAY, STE. 100 OCEANSIDE, CA 92054	(760) 681-5222	M – F, 8AM–6PM, SAT. 9A-2P
☐	TRI CITY MEDICAL CENTER **(FOR EMERGENCIES AND OUTSIDE NORMAL BUSINESS HOURS)**	4002 VISTA WAY OCEANSIDE, CA 92056	(760) 940-3590	CALL **WORKPARTNERS** FIRST -760-681-5222
☐	I CHOOSE TO BE TREATED BY THE **PREDESIGNATED PERSONAL PHYSICIAN** I HAVE ON FILE. I UNDERSTAND THAT THIS DESIGNATION MUST BE ON FILE WITH THE WORKERS' COMPENSATION DEPT. PRIOR TO THE DATE OF THIS INJURY AND THAT THE PHYSICIAN I HAVE CHOSEN HAS PREVIOUSLY TREATED ME, HAS MY MEDICAL RECORDS AND HAS AGREED TO TREAT ME IN THE EVENT OF A WORK-RELATED INCIDENT.			

I HAVE RECEIVED THE FOLLOWING FORMS AND INSTRUCTION SHEET:

1. Instructions for Reporting & Return to Work Guidelines
2. State Claim Form DWC – 1
3. Authorization for Medical Treatment
4. Notice to Employees
5. WC Benefits and Procedures
6. Incident Report of Illness or Injury
7. Prime (Complete Written Employee Notification regarding Medical Provider Network (MPN)
8. Temporary Prescription ID Card

EMPLOYEE SIGNATURE: ____________________ DATE: ____________

AUTHORIZED EMPLOYER REPRESENTATIVE NAME (PRINT): ____________________ TITLE: ____________

EMPLOYER REPRESENTATIVE SIGNATURE: ____________________ DATE: ____________

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MEDICAL PROVIDER BILLING INSTRUCTIONS:

FIRST AID CLAIMS:

OCEANSIDE UNIFIED SCHOOL DISTRICT
ATTN: MICHIYO DAVIS
2111 MISSION AVE
OCEANSIDE, CA 92058-2326
FAX: 760-967-7178

RECORDABLE CLAIMS:

AP KEENAN
PO BOX 2707
TORRANCE, CA 90509
TEL: (800) 654-8347
FAX: (951) 788-8013