

PARKWAY MEDICAL GROUP

Phone: 828-293-0333

Fax: 828-298-0050

NAME: _____ **D.O.B.** _____ **M/F**

ADDRESS: _____ **PHONE:** (____) _____

CITY: _____ **STATE:** _____ **ZIP:** _____

SS#: ____-____-____ **COMPANY:** _____

Please check and sign the appropriate consent:

COMPANY EVALUATION: (Physical, Drug/Alcohol Test, Respiratory Evaluation, etc.)
I permit the staff of Parkway Medical Group to perform a medical evaluation requested by The Company (employer). I also permit Parkway Medical Group to release the results of my evaluation to the management of the company for its own use in matters relating to my employment.

I understand and agree that if I knowingly give false or misleading answers during any phase of this medical evaluation, The Company will have sufficient grounds for terminating my employment.

I understand and agree that this examination is not designed to detect hidden or latent diseases. Neither Parkway Medical Group its staff, not The Company, shall be liable for damages in failing to detect any such diseases.

I release Parkway Medical Group and its staff from any claims or decisions resulting from this evaluation.

EMPLOYEE SIGNATURE: _____ **DATE:** _____

WITNESS SIGNATURE: _____ **DATE:** _____

WORKER'S COMPENSATION: (Injured at work)
I hereby authorize Parkway Medical Group to disclose to my employer/carrier any information necessary for the processing of my Workers Compensation claim related to treatment of my injury/illness at Parkway Medical Group. I understand that this authorization extends to the treatment, furnishing a copy of the treatment records and/or any other reports related to this treatment. The questions of privacy between Parkway Medical Group, my treating physician, and myself are waived as regards to the information contained in the records and reports furnished to my employer/carrier for this incident. In addition, authorization is hereby given to Parkway Medical Group to perform any and all tests, procedures, or physical examinations relative to my injury/illness as deemed necessary by the attending physician and/or my employer/carrier.

EMPLOYEE SIGNATURE: _____ **DATE:** _____

WITNESS SIGNATURE: _____ **DATE:** _____

PARKWAY MEDICAL GROUP
WORKERS' COMPENSATION HISTORY FORM

Please complete the following information so we may process your Workers' Compensation claim properly.

NAME: _____ SS#: ____-____-____ D.O.B. _____

AGE:____ DOMINANT HAND: R___L___ JOB:_____

EMPLOYER: _____

Did your employer authorize this visit? Yes ___ No ___

Name/Telephone of a person who can authorize:_____

Do you work for a temporary agency? Yes ___ No___ If so, Name: _____

Have you completed an accident report at work? Yes ___ No ___

HR Contact/Supervisor's Name:_____

Industrial Commission Form 19 completed and attached? Yes ___ No ___

Where do you hurt and how did you get injured? Date ___/___/___

Time:_____AM/PM

Pain: On a scale of **1** (low) to **10** (high), where do you rate your pain?

Please check "yes" or "no" for each of the following. The information you provide on this page is necessary to make informed decisions about your medical care. However, this information will be held in confidence and will not be revealed to your employer or insurance company.

CONDITION	YES	NO	COMMENT
1. Are you currently taking and medicine?			
2. Are you allergic to any medicines?			
3. What was the date of your last tetanus shot?			
4. Have you ever broken a bone?			
5. Have you ever had surgery?			
6. Are you pregnant/breastfeeding?			
7. Do you use tobacco products?			
8. Do you drink alcoholic beverages?			
9. Have you ever had severe joint pain?			
10. Have you ever injured your back?			

	YES	NO	COMMENT
11. Have you ever had: heart disease			
12. high blood pressure			
13. diabetes			
14. reaction to anesthesia			
15. ulcers			
16. epilepsy or seizures			
17. arthritis			
18. asthma			
19. emphysema			
20. bleeding problems			
21. Have you ever had medical care for severe depression or anxiety?			
22. Have you ever missed time from work due to an on-the-job injury?			
23. Have you ever had a rash/reaction because of exposure to an industrial product?			

I certify that the above answers are true and complete.

SIGNATURE: _____ DATE: _____

PARKWAY MEDICAL GROUP
TREATMENT PLAN
(To be completed by PMG Provider)
Ph: 828-298-0333 Fax: 828-298-0050

DATE OF VISIT: _____

Name:	Company:
Date/Time of Injury:	Chief Complaint:
SSN:	Time In:

Diagnosis: _____ <hr/> ICD.9 _____ In my opinion, this injury/illness is: <input type="checkbox"/> Work related <input type="checkbox"/> Not Work Related <input type="checkbox"/> Cause unknown at this time

<u>STATUS</u>
<input type="checkbox"/> Discharged to full duty on ___/___/___, no further care indicated at this time. <input type="checkbox"/> Returned to full duty on ___/___/___. <input type="checkbox"/> No change in current restrictions. <input type="checkbox"/> Excused from work today. <input type="checkbox"/> No work until _____. <input type="checkbox"/> Returned to work on ___/___/___/, with the following restrictions:
<u>TREATMENT</u>
<input type="checkbox"/> QED Performed/ Not Performed <input type="checkbox"/> Drug Screen Performed/ Not Performed <input type="checkbox"/> Tetanus Given/ Not Given <input type="checkbox"/> Medications: _____

<input type="checkbox"/> Limited/No bending or stooping	<input type="checkbox"/> No lifting with R/L hand prorated.
<input type="checkbox"/> Limited/No twisting of trunk.	<input type="checkbox"/> Limited/No use of vibrating or pounding tools
<input type="checkbox"/> No lifting over _____lbs.	<input type="checkbox"/> No use of R/L upper extremity.
<input type="checkbox"/> Limited pushing/ pulling.	<input type="checkbox"/> Must wear sling.
<input type="checkbox"/> Avoid prolonged sitting.	<input type="checkbox"/> Must wear splint/cast.
<input type="checkbox"/> Limited/No weight bearing R/L foot; crutches.	<input type="checkbox"/> Must keep wound(s) clean and dry.
<input type="checkbox"/> Limited/No kneeling or squatting.	<input type="checkbox"/> Must wear dressing(s).
<input type="checkbox"/> Limited/No prolonged standing.	<input type="checkbox"/> Limited/No work requiring depth perception.
<input type="checkbox"/> Limited/No stair/ladder climbing.	<input type="checkbox"/> Avoid bright lights
<input type="checkbox"/> May use R/L upper extremity as assist.	<input type="checkbox"/> No work around dangerous machinery.
<input type="checkbox"/> Limited/No flexion/extension of R/L wrist.	<input type="checkbox"/> No operation of mobile equipment.

<input type="checkbox"/> Limited/No repetitive use of R/L upper extremity.	<input type="checkbox"/> No exposure to : _____
<input type="checkbox"/> Other: _____	
<i>If suitable work cannot be found within these restrictions, this employee should be placed on medical leave.</i>	

Return Appointment Date: _____ Time: _____
 Physical Therapy Appointment Date: _____ Time: _____
 Consultation with: _____ M.D. Date: _____ Time: _____
 Referred to: _____ M.D. Date: _____ Time: _____
 Time Out: _____ **M.D. Signature:** _____

NOTE: *Any restrictions apply both on and off the job. I have received and understand the above instructions and agree to follow them.*

Patient Signature: _____

EMPLOYER'S REPORT OF EMPLOYEE'S INJURY OR OCCUPATIONAL DISEASE TO THE INDUSTRIAL COMMISSION

*Emp. Code # _____

*Carrier Code # _____

To the Employer:

A copy of this Form 19 accompanied by a blank Form 18 must be given to the employee. It does not satisfy the employee's obligation to file a claim. **The filing of this report is required by law.**

This form MUST be transmitted to the Industrial Commission through your Insurance Carrier.

Employer FEIN _____

Carrier File # _____

To the Employee:

This Form 19 is not your claim for workers' compensation benefits. To make a claim, you must complete and sign the enclosed Form 18 and mail it to Claims Administration, N.C. Industrial Commission, 4335 Mail Service Center, Raleigh, NC 27699-4335 within two years of the date of your injury or last payment of medical compensation. For occupational diseases, the claim must be filed within two years of the date of disability or the date your doctor told you that you have a work-related disease, whichever is later.

***Required Information.**

The I.C. File # is the unique identifier for this injury. It will be provided by return letter and is to be referenced in all future correspondence.

The use of this form is required under the provisions of the Workers' Compensation Act

Employee's Name _____		Employer's Name _____		Telephone Number () - _____	
Address _____		Employer's Address _____		City _____	State _____ Zip _____
City _____	State _____	Zip _____	Insurance Carrier _____	Policy Number _____	
Home Telephone () - _____		Work Telephone () - _____		Carrier's Address _____	
- -		/ /		City _____ State _____ Zip _____	
Social Security Number _____		Sex <input type="checkbox"/> M <input type="checkbox"/> F	Date of Birth _____		Carrier's Telephone Number () - _____
				Fax Number () - _____	

Employer	1. Give nature of employer's business _____				
	Time And Place	2. Location of plant where injury occurred _____ County _____ Department _____ State if employer's premises _____			
3. Date of injury / / 4. Day of week _____ Hour of day : <input type="checkbox"/> A.M. <input type="checkbox"/> P.M.					
5. Was employee paid for entire day _____ 6. Date disability began / / <input type="checkbox"/> A.M. <input type="checkbox"/> P.M.					
Person Injured	7. Date you or the supervisor first knew of injury / / 8. Name of supervisor _____				
	9. Occupation when injured _____				
	10. (a) Time employed by you _____ (b) Wages per hour \$ _____				
	11. (a) No. hours worked per day _____ (b) Wages per day \$ _____ (c) No. of days worked per week _____ (d) Avg. weekly wages w/ overtime \$ _____ (e) If board, lodging, fuel or other advantages were furnished in addition to wages, estimated value per day, week or month. \$ _____ per _____				
Cause And Nature Of Injury	12. Describe fully how injury occurred and what employee was doing when injured: _____ (Statement made without prejudice and without vouching for correctness of information)				
	13. List all injuries and specify body part involved (e.g. right hand or left hand): _____				
	14. Date & hour returned to work / / at : .M. 15. If so, at what wages \$ _____ per _____				
	16. At what occupation _____ 17. Employee's salary continued in full? _____				
	18. Was employee treated by a physician _____				
Fatal Cases	19. Has injured employee died _____ 20. If so, give date of death (Submit Form 29) / / _____				

Employer name _____ Date Completed / /
 Signed by _____ Official Title _____

OSHA 301 Information:

Case Number from Log: _____	Date Hired: / /	Time Employee began work on date of incident: _____ : <input type="checkbox"/> A.M. <input type="checkbox"/> P.M.	If off-site medical treatment provided, answer entire next line.
Name of facility: _____	Address: Street/City/Zip/Telephone _____		ER visit? <input type="checkbox"/> Yes <input type="checkbox"/> No Overnight stay? <input type="checkbox"/> Yes <input type="checkbox"/> No

Attention: This form contains information relating to employee health and must be used in a manner that protects the confidentiality of employees to the extent possible while the information is being used for occupational safety and health purposes.

SELF-INSURED EMPLOYER OR CARRIER MAIL TO:

NCIC - CLAIMS ADMINISTRATION
4335 MAIL SERVICE CENTER
RALEIGH, NORTH CAROLINA 27699-4335
MAIN TELEPHONE: (919) 807-2500
HELPLINE: (800) 688-8349
WEBSITE: HTTP://WWW.IC.NC.GOV/

FOR IC USE ONLY
RESEARCHER: _____
CC: _____
EC: _____
DATA ENTRY: _____

IMPORTANT INFORMATION FOR EMPLOYER

Employer must furnish a copy of this form, as completed, to the employee or the employee's representative when submitted to the Insurance Carrier or Claims Administrator for transmission to the Commission. Every question must be answered. This Form 19 must be transmitted to the Commission through your insurance carrier/claims administrator, and is required by law to be filed within 5 days after knowledge of accident. Employer must also give employee a blank Form 18.

IMPORTANT INFORMATION FOR EMPLOYEE

Reporting an Injury

If you do not agree with the description or time of the accident given on this form, you should make a written report of injury to the employer within thirty (30) days of the injury.

Making A Claim

To be sure you have filed a claim, complete a Form 18, Notice of Accident, within two years of the date of the injury and send a copy to the Industrial Commission and to your employer. The employer is required by law to file this Form 19, but the filing of the Form 19 does not satisfy the employee's obligation to file a claim. The employee must file a Form 18 even though the employer may be paying compensation without an agreement, or the Commission may have opened a file on this claim. A claim may also be made by a letter describing the date and nature of the injury or occupational disease. This letter must be signed and sent to the Industrial Commission and to your employer.

FOR ASSISTANCE OR TO OBTAIN A FORM 18 FROM THE INDUSTRIAL COMMISSION, YOU MAY CALL (800) 688-8349

USE YOUR I.C. FILE NUMBER (IF KNOWN) OR SOCIAL SECURITY NUMBER ON
ALL FUTURE CORRESPONDENCE WITH THE COMMISSION

[SPANISH TRANSLATION]

INFORMACIÓN IMPORTANTE PARA LOS EMPLEADOS

Reporte de una Lesión (Reporting an Injury)

Si usted no está de acuerdo con la descripción o la hora del accidente que aparece en el formulario, debe hacer un reporte de la lesión por escrito y dárselo a su empleador dentro de un período de treinta (30) días a partir de la fecha de la lesión.

Cómo Presentar una Reclamación (Making a Claim)

Para cerciorarse de que ha presentado una reclamación, complete el Formulario 18 Notificación de Accidente dentro de un período de dos años a partir de la fecha de la lesión y envíe una copia a la Comisión Industrial y una copia a su empleador. Por ley, el empleador debe presentar el Formulario 19, sin embargo, el presentar el Formulario 19 no cumple con la obligación que tiene el empleado de presentar una reclamación. El empleado debe presentar el Formulario 18 aunque el empleador esté pagando compensación sin tener un acuerdo o si la Comisión ha creado un expediente con respecto a esta reclamación. También se puede presentar una reclamación por medio de una carta explicando la fecha y la naturaleza de la lesión o la enfermedad ocupacional. Esta carta se debe firmar y enviar a la Comisión Industrial así como al empleador.

**PARA RECIBIR ASISTENCIA O PARA OBTENER EL FORMULARIO 18 DE LA COMISIÓN INDUSTRIAL, USTED
PUEDE HABLAR AL (800) 688-8349**

EN TODA LA CORRESPONDENCIA QUE ENVÍE A LA COMISIÓN INDUSTRIAL POR FAVOR ESCRIBA
EL NÚMERO DE CASO DESIGNADO POR LA COMISIÓN [I.C. FILE NUMBER] (SI LO SABE)
O SU NÚMERO DE SEGURO SOCIAL.