No c o o d

(To be presented to doctor, hospital, or clinic by injured party when reporting for treatment)

_____ has reported that he/she was injured in our
(employee name)

employ on _____.
(date of injury)

Please forward all reports and bills to the following address:

South Carolina School Boards Insurance Trust
Attn: Workers' Compensation
111 Research Drive
Columbia, SC 29203

_____ _____
School Location / Employer Phone

_____ _____
Employer Signature (authorizing treatment) Date

_____ _____
Approved Physician for treatment Phone

NOTE: This is not an acceptance of liability.

Return to Work Notice
(To be completed by Doctor after examining employee)

Name of Doctor's Office/Clinic _____

Location _____ Phone _____

Diagnosis _____

Employee **IS** able to return to <u>regular duties</u> at this time.

Employee **IS** able to return to <u>light duties</u> at this time, **list limitations**: _____
_____

Employee **IS NOT** able to return to work at this time because: _____

_____ _____
Request Referral to: (if applicable) Follow-up appointment date

_____ _____
Signature (Doctor) Date

Please return completed form to patient to be returned to School / District Office.

Original copy: District Office Pink Copy: Patient