

Treatment to be provided by:
CONCENTRA

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 Fire Dept.- City of Charlotte CMPD- 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 Screening: Yes No Alcohol Screening: Yes No DOT Alcohol/Drug Screen 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
To be filled out by the Physician

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 _____