THE UNIVERSITY OF ALABAMA IN HUNTSVILLE

EMPLOYEE OCCUPATIONAL INJURY CLAIM

General Information

Name: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Home: (_____)_____-_____ Work: (_____)_____-_____ Cell: (_____)_____-_____

Email Address: _____

Work Address: _____ Supervisor: _____

Health Insurance Carrier: _____

Health Insurance Contract Number: _____ Group Number: _____

Were claims filed with your health insurance provider for all eligible expenses for the treatment of the injuries sustained? ____Yes ____ No Date of Birth: _____ Social Security No.: _____

Accident Information

Date of Accident: _____ Time of Accident: _____:_____ _____ A.M. _____ P.M.

Location of Accident: _____

Witnesses to Accident: _____

Activity engaged in when accident occurred: _____

_____

Summarize how accident occurred: _____

_____

Injuries sustained in the accident: _____

_____

Medical Treatment Information

Date you first obtained medical assistance for the injuries sustained: _____

Names and locations of medical facilities from which you obtained medical assistance (doctor's office, urgent

care clinic, hospital, ambulance service, pharmacy, prosthetic store):

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Work Absence - Election

Did your injuries cause you to be absent from work? ____ Yes ____ No
Do you wish to charge the time absent from work to: ____ Sick Leave ____ Annual Leave ____ Lost Wage Benefits

Medical Records Release

This is to authorize you to disclose/discuss all medical record information pertaining to my on-the-job injury to/with my employer, the University of Alabama in Huntsville. This information will be used to determine qualification for lost wage and/or medical expense benefits. You are authorized to accept a xerox copy of this authorization in lieu of the original.

1. The type of information to be used or disclosed is as follows:

    - All medical notes and/or reports in my file relating to this particular injury, as well as all notes and/or reports documenting a pre-existing injury that is the same in nature. (Including, but not limited to, medical history, physicals, operative notes, pathology reports, consultation reports, EKG reports, diagnostic studies, nurses' notes, progress notes, physician's orders, outpatient records, emergency department records, laboratory results, imaging results, and discharge summarys.)

    - A statement of account detailing all expenses incurred, payments made by my insurance provider, charge-off amounts, as well as any insurance co-payments I have made concerning this particular injury.

2. I understand that the information in my health record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus

(HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and/or drug abuse.

3. I understand that once the information is disclosed pursuant to this authorization, it may be redisclosed by the recipient and the information may not be protected by federal privacy regulations.

4. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to your Medical Records Department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

5. Unless otherwise revoked, this authorization will remain valid until I no longer require medical assistance for my injuries sustained in this incident or until my physician feels I have reached maximum medical improvement (MMI).

6. I understand that if I refuse to sign this Medical Records Release the University can not process my claim, therefore no lost wage and/or medical expense benefits will be provided.

I hereby certify that the facts and circumstances stated above regarding my occupational injury are true and correct to the best of my knowledge and that all medical and drug expenses for which I am claiming reimbursements were incurred by me in connection with treatment of such injury.

X _____ **X** _____

CLAIMANT'S SIGNATURE **DATE**

STATE OF ALABAMA)
MADISON COUNTY)

Sworn to before me and subscribed in my presence this _____ day of _____ 20____.

_____

NOTARY PUBLIC

MY COMMISSION EXPIRES: _____