

Workers' Compensation—Early Return to Work Program  
Sindecuse Health Center  
Phone (269) 387-3281 • Fax (269) 387-2944

OSHA Case # \_\_\_\_\_

**Instructions:** Please complete all items in Part 1 and provide signature and date. Bring completed, signed form with you to the Sindecuse Health Center (or other treating facility/physician), who will complete Part 2.

<b>Part 1—To be completed by Supervisor/Employee</b>			
Date and Time of Accident/Injury / / at <input type="checkbox"/> a.m. <input type="checkbox"/> p.m.		Employee Social Security #	
Employee Name (Last, First, and Middle Initial)		Date of Birth	Marital Status <input type="checkbox"/> Single <input type="checkbox"/> Married
Address (Number, Street, City, State, and Zip Code)			
Home Phone No. ( )	Job Title	Department (at time of injury)	
Employment Status: <input type="checkbox"/> Regular Employee <input type="checkbox"/> Student Employee <input type="checkbox"/> Temporary Employee			
Was accident/injury witnessed? <input type="checkbox"/> No <input type="checkbox"/> Yes—Name of Witness: _____			
Type of alleged injury (strain, sprain, cut, bruise, burn, etc.)		Part of the Body <input type="checkbox"/> Left <input type="checkbox"/> Right	
Describe <b>specifically</b> how alleged accident occurred. Include as much detail as possible in allotted space.			
Location of accident		Building	Room/Floor
Supervisor Signature		Date Signed	
I hereby authorize any physician, hospital, agency, or organization to disclose to Western Michigan University or their agent any medical information or reports regarding history, examinations, treatments, and medications received by me at their request.			
Signature of Injured Employee		Date Signed	
<b>Part 2—Doctor's Findings or Disposition - <input type="checkbox"/> Sindecuse Health Center <input type="checkbox"/> Other: _____</b>			
Diagnosis			
Treatment: <input type="checkbox"/> Lab Test <input type="checkbox"/> X-Ray <input type="checkbox"/> Referred to Consultant <input type="checkbox"/> Prescription Drug/Duration of RX _____ <input type="checkbox"/> Physical Therapy <input type="checkbox"/> Other _____			
Patient is: <input type="checkbox"/> Able to resume regular duties <input type="checkbox"/> Able to resume regular duties on (date) _____ <input type="checkbox"/> Restricted Duties—See remarks below <input type="checkbox"/> Unable to return to work <input type="checkbox"/> To return for recheck on (date) _____			
Diagnosis: <input type="checkbox"/> Occupational <input type="checkbox"/> Non-Occupational <input type="checkbox"/> Undetermined			
Remarks			
Physician Signature		Date Signed	
<b>OFFICE USE ONLY</b>			
Location Code _____ Entered: / /		Case Status: _____ Federal Tax ID #38-6007327	
<b>Distribution</b> Original: Sindecuse Health Center		<b>Make four copies and distribute to:</b> Workers' Compensation Office Employee - 2 copies (1 for employee & one for employee to return to his/her supervisor) Billing copy	
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