EMPLOYEE OCCUPATIONAL INJURY CLAIM

General Information

Name: _____

Home Address: _____

City: _____ State: _____ Zip: _____

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

Email Address: _____

Work Address: _____ Supervisor: _____

_____

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: _____

(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: _____