School District

Employee's Authorization for Medical Attention

_________________________________ , is authorized to leave the premises of the Board of Education to seek medical attention for an injury or illness reported to the first undersigned at _________ ☐ a.m. ☐ p.m., on ______/______/______.

The Board of Education is not in a position to determine whether or not the injury is compensable within the meaning of the New Jersey Worker's Compensation Law. However, it is the intent of the Board of Education to provide its employees and authorized treating physicians with an answer to the question of compensability as soon as possible. Therefore, the employee receiving this form is required to have the treating medical provider complete this form at the time of his/her initial treatment.

First Undersigned:_____________________________ Date: _________________
(Claim Coordinator, Principal, Nurse or Supervisor)

Second Undersigned: __________________________ Date: _________________
(Injured Employee)

Initial Complaint: ____

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Instructions to Medical Provider

Please complete and sign this form, then fax it and the ***Workers' Compensation Treatment And Status Report*** to our Claim Administrator and to the Board of Education at the addresses and facsimile numbers shown below. Your prompt attention to this request will help speed up all processes resulting in a more efficient delivery of services to our employee and faster processing of claim activity.

Signed: ______________________________________ Date: _________________
(Medical Provider)

Fax Completed Form To:

Qual-Lynx
ACCASBOJIF/BCIPJIF/GCSSDJIF Claims
100 Decadon Drive
Egg Harbor Twp., NJ 08234
Phone: 609-653-8400
Fax: 609-926-9270 (General)
609-601-3196 (Worker's Comp)

School District Name and Address
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Copy To District Claim Coordinator

Copy To Medical Provider