UAB ON-THE-JOB INJURY/ILLNESS PROGRAM

Initial Medical Evaluation Authorization

This form must be completed, signed and presented to the medical service provider prior to receipt of treatment, except in the event of a serious medical emergency.

THIS UAB EMPLOYEE, _____ (_____),
Full Name of Employee *Social Security Number*

IS REFERRED TO _____ FOR EVALUATION OF THE INJURY/
Medical Service Provider

ILLNESS DESCRIBED BELOW. *AN INCIDENT REPORT MUST BE COMPLETED AND SUBMITTED AS REQUIRED BY THE OJI PROGRAM POLICY OR REFER TO THE **OJI PROGRAM** ONLINE AT UAB.EDU/EMPLOYEERELATIONS.*

EMPLOYEE'S DEPARTMENT: _____ EMPLOYEE'S POSITION/TITLE: _____

DATE INCIDENT OCCURRED: _____

BRIEF DESCRIPTION OF INCIDENT AND RESULTING INJURY OR ILLNESS: _____

_____

_____

_____

EMPLOYEE SIGNATURE: _____ DATE SIGNED: _____

SUPERVISOR SIGNATURE: _____ DATE SIGNED: _____

SUPERVISOR PHONE NUMBER: _____

Completion of this form does not certify that the injury or illness described above is an "on-the-job injury/illness" qualifying for benefits under the UAB On-the-Job Injury/Illness Program. An **OJI Benefits Application*** must be completed, signed and submitted to Brentwood Services Administrators as noted in the **How to Apply for OJI Benefits*** document.

***Forms can be accessed on the Instructions and Forms for OJI webpage at uab.edu/employeerelations under "On-the-Job Injury."**