OCEANSIDE UNIFIED • SCHOOL • DISTRICT

WORKERS' COMPENSATION/ RETURN TO WORK OFFICE
2111 MISSION AVENUE, OCEANSIDE, CA 92058-2326
PHONE: 760-966-4035 FAX: 760-967-7178

AUTHORIZATION FOR MEDICAL TREATMENT

WORK-RELATED EMPLOYEE INJURY

EMPLOYEE NAME: ______________________________

JOB TITLE: ______________________ EMPLOYMENT SITE: ______________________

DATE OF INJURY: ______________________ TIME OF INJURY: ______________ ☐ AM ☐ PM

PLEASE CHOOSE AN OPTION BELOW:

☐ **I ACCEPT** MEDICAL TREATMENT.
COMPANY NURSE CONTACTED? ☐ YES ☐ NO
IF INSTRUCTED BY THE COMPANY NURSE, PROCEED TO THE MEDICAL PROVIDER SELECTED BELOW.

☐ **I DECLINE** MEDICAL TREATMENT AT THIS TIME. ADDITIONALLY, I UNDERSTAND THAT IF I SHOULD NEED MEDICAL TREATMENT AT A LATER DATE, I WILL NOTIFY MY SUPERVISOR & THE WORKERS' COMPENSATION DEPT.

NOTE: MEDICAL EXAMINATIONS OUTSIDE OF THE PROVIDERS LISTED BELOW MAY RESULT IN CLAIM & TREATMENT DELAYS

√	MEDICAL PROVIDER	ADDRESS	PHONE	HOURS
☐	AKESO OCCUPATIONAL HEALTH (FORMERLY WORKPARTNERS)	3156 VISTA WAY, STE. 100 OCEANSIDE, CA 92054	(760) 681-5222	M – F, 8AM–6PM, SAT. 9A-2P
☐	TRI CITY MEDICAL CENTER **(FOR EMERGENCIES AND OUTSIDE NORMAL BUSINESS HOURS)**	4002 VISTA WAY OCEANSIDE, CA 92056	(760) 940-3590	CALL **AKESO** FIRST - 760-681-5222
☐	I CHOOSE TO BE TREATED BY THE **PREDESIGNATED PERSONAL PHYSICIAN** I HAVE ON FILE. I UNDERSTAND THAT THIS DESIGNATION MUST BE ON FILE WITH THE WORKERS' COMPENSATION DEPT. PRIOR TO THE DATE OF THIS INJURY AND THAT THE PHYSICIAN I HAVE CHOSEN HAS PREVIOUSLY TREATED ME, HAS MY MEDICAL RECORDS AND HAS AGREED TO TREAT ME IN THE EVENT OF A WORK-RELATED INCIDENT.			

EMPLOYEE SIGNATURE: ______________________ DATE: ______________

AUTHORIZED EMPLOYER REPRESENTATIVE NAME (PRINT): ______________________ DATE: ______________

EMPLOYER REPRESENTATIVE SIGNATURE: ______________________ TITLE: ______________

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MEDICAL PROVIDER BILLING INSTRUCTIONS:

FIRST AID CLAIMS:

OCEANSIDE UNIFIED SCHOOL DISTRICT
ATTN: MICHIYO DAVIS
2111 MISSION AVE
OCEANSIDE, CA 92058-2326
FAX: 760-967-7178

RECORDABLE CLAIMS:

KEENAN
PO BOX 2707
TORRANCE, CA 90509
TEL: (800) 654-8347
FAX: (951) 788-8013