MEDICAL SERVICE ORDER

Workers' Compensation Department
San Bernardino City Unified School District
777 North F Street
San Bernardino, CA 92410

To Doctor: Company Nurse Assigned Medical Provider ____________________
Address: ____
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Employee: ____ was injured

On (date) ______________________ at (time) ________________ while in our employ.

Doctor: ______________________________

Please provide the necessary medical attention to our injured employee.

Please be advised that the San Bernardino City Unified School District has a very strong light duty program. The District will provide the employee with either a short-term modification of his/her position OR a short-term alternate position within your recommended activity restrictions. After completing medical evaluations or treatment, provide the employee with a Work Status Report that outlines their work restrictions to provide to their supervisor or site secretary. You may call the Workers' Compensation Department at (909) 381-1166 if you have any questions.

Employer: San Bernardino City Unified School District
Address: 777 North F Street, San Bernardino, CA 92410
Signed by: ____________________ Date: ______________
Title: ______________________________________

Form RM-87 (Rev. 03/08/24)

Original: Doctor
Photocopies: Employee's Site
Worker's Compensation