WORKERS' COMPENSATION
EXAMINATION AND WORK STATUS FORM
Mississippi School Boards Association
Workers' Compensation Trust

To be Completed by Employer

Claimant _____ SS# _____

Address _____ Date of Birth _____

City & State _____ Zip Code _____

Job Title _____ Phone _____

School: _____

DATE & TIME OF ACCIDENT/INJURY _____

NATURE OF INJURY _____

Employee's Signature _____ **Date** _____

Authorized Signature _____ **Date** _____

PHYSICIAN TO COMPLETE

DATE OF SERVICE _____

CURRENT COMPLAINT _____

DIAGNOSIS _____

Work Status:

_____Temporarily Unable to Return to Work

_____Return To Work On _____

_____Restrictions As Follows _____

_____Return to Work No Restrictions

Date of Follow-up Appointment (if applicable) _____

PHYSICIAN'S SIGNATURE _____ **DATE** _____

PHYSICIAN'S ADDRESS _____

PHONE # _____

****PLEASE FAX FORM TO THE CLAIMS ADMINISTRATOR, CORVEL CORPORATION**
Fax Number: 1-866-434-4720 Telephone: 601-863-2740

To obtain a Pre-certification of Medical Necessity: Call 1-800-278-6602