



No c o o d

(To be presented to doctor, hospital, or clinic by injured party when reporting for treatment)

_____ has reported that he/she was injured in our
(employee name)
employ on _____.
(date of injury)

Please forward all reports and bills to the following address:

**South Carolina School Boards Insurance Trust
Attn: Workers' Compensation
111 Research Drive
Columbia, SC 29203**

School Location / Employer Phone _____

Employer Signature (authorizing treatment) Date _____

Approved Physician for treatment Phone _____

NOTE: This is not an acceptance of liability.

Return to Work Notice

(To be completed by Doctor after examining employee)

Name of Doctor's Office/Clinic _____
Location _____ Phone _____
Diagnosis _____

Employee **IS** able to return to regular duties at this time.

Employee **IS** able to return to light duties at this time, **list limitations:** _____

Employee **IS NOT** able to return to work at this time because: _____

Request Referral to: (if applicable) Follow-up appointment date _____

Signature (Doctor) Date _____

Please return completed form to patient to be returned to School / District Office.

Original copy: District Office

Pink Copy: Patient