INDIANA UNIVERSITY

EMPLOYER NOTIFICATION FOR TREATMENT FOR ON-THE-JOB INJURY/ILLNESS

Instructions for IU supervisor completing this form:
Send one copy of this form with the employee in person (or fax it) to the authorized medical provider. Send one copy to Workers' Compensation.

The Occupational Injury/Illness Form is to be completed along with this document and sent to Workers' Compensation as soon as possible.

Workers' Compensation
Email: workcomp@iu.edu
Fax: 812-855-2720

Date: ___ / ___ / ___

To (name of authorized medical provider): ___

From (IU department): ___

Employee name: ___ ID: ___ Date of birth: ___ / ___ / ___

Supervisor name: ___ Phone: ___ FAX: ___

Describe the Injury/Illness (Identify the part of the body injured (left, right, or bilateral) describe the nature of the injury.)

How did injury/illness occur? (use additional page if necessary)

Onset of illness/injury: Date ___ / ___ / ___ Time of illness/injury ___

This statement authorizes the medical provider named above to provide such medical and/or surgical services as may be necessary to properly care for the injury/illness diagnosed or to perform the service indicated to the above named employee. Indiana University assumes full responsibility for all charges incurred for the initial services rendered.

IU supervisor/authorized designee signature: ___ Phone: ___

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