Employer Notification for Treatment for On-the-job Injury/Illness

To (name of medical provider)_____Date:_____

From: IU Department _____

Employee _____ ID_____ Date of Birth ____/____/_____

Supervisor _____ Phone_____ FAX _____

Description of Injury/Illness (including body site)

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.

_____ _____

(Signature of IU Supervisor/Authorized Designee) Telephone

Instructions for IU supervisor completing this form:

Send one copy of this form with the employee in person or fax it to the medical provider. Fax one copy to Workers' Compensation 812-855-2720. Also complete the Occupational Injury Illness Form and fax it to Workers' Compensation as soon as possible.