**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**