Participant's First Report of Injury
Youth/Adult Work Experience

The UniqueHR Claims Department has been notified of a work related injury. In order to accurately process your claim, please legibly complete all sections of this form. Attach additional sheets if necessary.

Participant's Name: _____ **SSN:** _____ **Date of Birth:** _____
Last First MI

Home Telephone:_____ **Date of Injury:** _____ **Time of Injury:** _____

Alternate Telephone: _____ **Date Reported to Supervisor**: _____

Physical Address:_____ **Client Company:** _____

City: _____ **State:** _____ **Zip:** _____

Mailing Address: _____

City: _____ **State:** _____ **Zip:** _____

No. of Dependents: _____ **Marital Status:** _____

Sex: M / F **Language Preference:** _____

Description of What Caused the Injury:

_____

_____

_____

_____

What Were You Doing at the Time of the Accident? :

_____

_____

_____

_____

_____

What Body Part(s) Were Injured? Please Be Specific:

_____

_____

_____

_____

Information Release

I hereby authorize any licensed physician, medical practitioner, hospital, clinic or other medical related facility, insurance company or other organization institution or person that has any records or knowledge of me, or my health, to furnish to UniqueHR any and all information relevant to the injury/illness which I have sustained, including: medical history, drug/alcohol screening results, consultation reports, hospital records for the purpose of billing payment and treatment or consultation. Except to the extent actions have already been taken in reliance on this authorization, at any time I can revoke this authorization. This authorization will expire 180 days from the date of signature. A photocopy of this authorization shall be considered as effective and valid as the original.

Signature: _____ Date: _____

Refusal of Treatment

I hereby release UniqueHR of any responsibility for medical treatment to the injury obtained on _____ (date). I was injured at that time but do not feel that I require treatment. I understand that UniqueHR is obligated to offer me medical treatment and will for any injury that has occurred while on the job. However, I refuse treatment due to

_____

_____.

I also understand that by signing this form I am releasing UniqueHR of all responsibility to my injury. I understand that if I seek medical treatment through outside sources, UniqueHR is alleviated of all payment obligations. It has been explained to me that a drug/alcohol test will be performed, and a refusal to submit to these tests will result in my termination of employment. I swear that I am signing this form voluntarily and willingly.

Signature: _____ Date: _____

4646 Corona Drive, Suite 100
Corpus Christi, Texas 78411

Telephone: 800.824.8367
Fax: 866.516.7270

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Provide the Location of the Accident. Provide the Physical Address, If Possible:

_____

List Witness (es):

Name: _____ **Telephone:** _____

Name: _____ **Telephone:** _____

Name: _____ **Telephone:** _____

Supervisor: _____ **Telephone:** _____

Did You Seek Medical Treatment? Yes ☐ **No** ☐

If Yes, Please Provide the Following Information:

Physician Name: _____ **Physician Phone:** _____

Has the Doctor Removed You From Work? Yes ☐ **No** ☐ **Date of Next Doctor's Appointment:** _____

If Yes, What Was the First Day You Missed? _____ **Have You Returned to Work? Yes** ☐ **No** ☐

If Yes, What Date? _____

Participant's Email: _____

UniqueHR, has an active return to work program for all of its injured employees. Should I be injured during the course and scope of my employment, I should inform the attending physician of this program.

By my signature below, I agree that I have examined this form and the information written above relating to my injury. This information is accurate and true. I have also read the note above regarding the return to work program, and will contact the UniqueHR Claims Department regarding this program.

Signature: _____ **Date:** _____

AUTHORIZATION TO RELEASE MEDICAL INFORMATION
*This medical authorization form complies in all respects with HIPAA.

I hereby authorize and request _____
to disclose to **UniqueHR** (hereinafter "Employer"); Johnston and Associates, DBA OccuSure Claims, Compass Managed Care, and the designated workers compensation insurance carrier (hereinafter "Insurer"); or their representative counsel; any information or opinion they may request regarding any physical condition and any treatment which has been rendered to me, including but not limited to diagnosis and prognosis, and allow the representatives and/or agents of Employer, Insurer, or their representative counsel to see and copy any and all records available, including but not limited to x-rays, regarding my condition and treatment and/or all of my hospital records and charts. I understand that the Employer, Insurer, or their representative counsel is requesting this information in connection with a workers' compensation matter in which I am involved. I also understand that the Employer, Insurer, or their representative counsel will be responsible for the charges incurred in obtaining this information. I understand that the information in my medical record may include information relating to treatment of drug or alcohol abuse, mental health, sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), AID related complex (ARC) and/or human immunodeficiency virus (HIV).

The Employee also expressly and unequivocally consents to allow the representatives and/or agents of Employer, Insurer, or their representative counsel; to have direct verbal or written contact and communication with all treating physicians, informally and without the employee present, regarding any and all confidential information related to the Employee's health disclosed or gained through the physician-patient relationship, regardless of the relation of said information to the alleged workers compensation claim. This authorization is valid for five (5) years from the date of execution.

I understand that I have the right to revoke this authorization in writing; however, in order to revoke this authorization I must give written notice of my intent to revoke this authorization to the Employer, Insurer, or representative counsel at least thirty (30) days prior to the date the revocation is to take effect. I also understand and agree that any information used or disclosed pursuant to this authorization may be subject to redisclosure by Employer, Insurer, or representative counsel, and the information may not be protected by federal confidentiality rules.

I understand that I may inspect or copy the protected health information received by Employer, Insurer, or representative counsel procured exclusively as a result of this authorization by submitting a written request to Employer, Insurer, or representative counsel.

I further understand that I do not have to sign this authorization; however, I have freely signed this authorization. I also acknowledge that I have received a signed copy of this authorization. I have read, fully understand, and heretofore consent to all aspects of this authorization, as evidenced by my signature below.

A copy or facsimile of this document shall have the same validity and effect as the original.

EXECUTED this _____ day of _____, 20___.

_____

EMPLOYEE/PATIENT (Signature)

_____

DATE OF BIRTH: SOCIAL SECURITY NUMBER