

**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