



This is a Worker's Compensation Treatment Authorization Form. This Form is not a guarantee of eligibility or compensability for Workers' Compensation Benefits.

To be completed by employer (please print)

Employer Name: **Cobb County Account # 0808899**

Employer Address: _____

Employee Name: _____

Social Security Number: _____ Date of Injury: _____

Type of Injury: _____

Body Part Injured: _____

Supervisor issuing form: _____

Supervisors: Please give this completed form to the injured employee to take with them to the physician. You must file the First Report of Injury with the PMA within 24 hours of injury.

This form is for one time use, only on this date _____.

Providers: You must call The PMA Management Corp toll free at 888-476-2669 prior to any additional treatment/admission or referral, other than an emergency situation. In an emergency situation, notification to PMA is required within 24 hours.

	<p><u>Send Medical Bills and Medical Reports to:</u></p> <p>PMA Customer Service Center PO Box 5231 Janesville, WI 53547-5231</p>	
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Cobb County Government
WORKERS' COMPENSATION
 Work Status

To be completed by treating physician and returned to the employee.

** PHYSICIAN'S REPORT **		
Employee Name:	Date of Injury:	
Date of Treatment:	Time Arrived:	Time Dismissed:
Diagnosis:		
		Work Related? Yes No

Patient's Status Report:

Able to return to normal duties. Unable to work until next scheduled visit. _____

Able to work with the following limitations:

- Sedentary Work Only
- Sedentary Work: Lift/Carry 10lbs Occasionally
- Light Work: Lift/Carry 20lbs Occasionally, 10lbs Frequently
- Medium Work: Lift/Carry 50lbs Occasionally, 20lbs Frequently
- Heavy Work: Lift/Carry 100lbs Occasionally, 50lbs Frequently, 20lbs Continuously
- Very Heavy Work: Lift/Carry 100lbs Occasionally, over 50lbs Frequently, over 20lbs Continuously

	Most of the time	Sometimes	Never
Drive during Work Hours	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Work on Unprotected Heights	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Work with Moving Machinery	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Operate Automotive Equipment	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Dismissed/Released from Care.

Next Scheduled Appointment Date:	Time:
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Printed Name of Physician:

Physician's Signature:

** MEDICAL PROVIDER **

****IMPORTANT INFORMATION****

All bills and medical records should be mailed to:
 PMA Companies
 PO Box 5231
 Janesville, WI 53547
 Fax 1-800-432-9762
 Email: claimsmail@pmagroup.com



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