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