REPORT OF INJURY

WORKERS' COMPENSATION PROGRAM
THE NAVAJO NATION - P.O. BOX 2489
WINDOW ROCK, AZ 86515-2489
PHONE: 928-871-6839
FAX: 928-871-6083

Workers' Comp Use Only	
Claim #	
Date Received	

Employer

1. Name of Company/Department/Program/Chapter/Enterprise		2. If PEP; Project Number	
3. Address	4. City or Town	5. State	6. Zip Code
7. Mailing Address – if different from above		8. Phone Number	9. Fax Number

Accident

10. Location Where Accident Occurred			11. Employers Premises Yes ☐ No ☐
12. Date of Injury	13. Time of Injury	14. Time work day begins	15. Date Disability Began
16. Was Injured Paid in Full for this Day Yes ☐ No ☐		17. Date supervisor was notified of injury	
18. Immediate Supervisors name		19. Supervisor's Phone Number	
20. Name, address and phone number of witness:		21. Name, address and phone number of witness:	

Injured Employee

22. Employee's Name (First, Middle, Last)	23. Gender	24. Social Security Number	25. Date of Birth
26. Mailing Address	27. City	28. State	29. Zip Code
30. Physical Address	31. Phone Number	32. Email Address	
33. Marital Status Married ☐ Single ☐ Divorced ☐ Widowed ☐		34. Date Hired	
35. Occupation when injured	36. How long at present occupation when injured	37. Employment Status Regular ☐ Temp ☐ Elected Official ☐ Volunteer ☐	
38. Number of hours worked per day:	39. Number of days worked per week:	40. Hourly wage at the time of injury:	
41. Other wages earned such as tips, stipends or other income is furnished in addition to regular wages, give amount: $ Per			
42. Date employee returned to work	43. Estimate length of disability Fr: To:	44. Type of leave taken Annual ☐ Sick ☐ Comp ☐ LWOP ☐ PTO ☐	

Cause of Injury

45. Describe in detail how accident happened and what employee was doing when injured. (Do not state "See Attached")

Nature of Injury

46. Describe the nature of the injury of diseases in detail and indicate the part of the body effected (e.g., Right? Left? Both) (Do not state "See Attached")		
47. Is the employee likely to lose more than seven (7) days due to injury/disease	48. Name of Physician and address	
49. Address of hospital		50. Date of first examination
51. If no treatment, does employee plan to seek medical treatment	52. FATAL CASE ONLY. Has injured died?	53. Date of Death if Applicable

Report Completed By		*NNWCP Date Stamp Here:*
Signed By		
Title	Date	

ARE ALL ITEMS COMPLETED? SIGN AND MAIL IMMEDIATELY TO THE ABOVE ADDRESS.

CONSENT TO DEVELOP
MEDICAL AND WAGE INFORMATION

"I hereby consent and request that the bearer be permitted to examine and obtain copies of all hospital and medical records of every sort and kind, interview doctors and other attendants regarding all matters relating to examination, diagnosis, care and treatment of myself. I further consent and request that the bearer be permitted to interview and correspond with all employers regarding all matters relating to my earnings and loss of earnings."

"I am willing that a Photostat of this authorization be accepted with the same authority as the original."

Date _____ Sign _____

Print (Name) _____

Address _____

_____

Workers' Compensation Program
THE NAVAJO NATION
Post Office Box 2489
Window Rock, Arizona 86515
Phone #: (928)871-6389

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DEPARTMENT OF HEALTH AND HUMAN SERVICES
Indian Health Service

FORM APPROVED: OMB NO. 0917-0030
Expiration Date: 08-31-2019
See OMB Statement on Reverse.

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

COMPLETE ALL SECTIONS, DATE, AND SIGN

I. I, _____, hereby voluntarily authorize the disclosure of information from my health record. *(Name of Patient)*

II. The information is to be disclosed by:	**And is to be provided to:**
NAME OF FACILITY	NAME OF PERSON/ORGANIZATION/FACILITY NN Workers' Compensation Program
ADDRESS	ADDRESS PO Box 2489
CITY/STATE	CITY/STATE Window Rock, AZ

III. The purpose or need for this disclosure is:

☐ Further Medical Care ☐ Attorney ☐ School ☐ Research ☒ Other *(Specify)* To determine eligibility of benefits
☐ Personal Use ☐ Insurance ☐ Disability ☐ Health Information Exchange (IHS/Other _____)

IV. The information to be disclosed from my health record: *(check appropriate box(es))*

☐ Only information related to *(specify)* _____

☐ Only the period of events from _____ to _____
☐ Other *(specify) (CHS, Billing, etc.)* _____
☐ Entire Record

If you would like any of the following sensitive information disclosed, check the applicable box(es) below:

☐ Alcohol/Drug Abuse Treatment/Referral ☐ HIV/AIDS-related Treatment
☐ Sexually Transmitted Diseases ☐ Mental Health *(Other than Psychotherapy Notes)*
☐ Psychotherapy Notes ONLY (by checking this box, I am waiving any psychotherapist-patient privilege)

V. I understand that I may revoke this authorization in writing submitted at any time to the Health Information Management Department, except to the extent that action has been taken in reliance on this authorization. If this authorization was obtained as a condition of obtaining insurance coverage or a policy of insurance, other law may provide the insurer with the right to contest a claim under the policy. If this authorization has not been revoked, it will terminate one year from the date of my signature unless a different expiration date or *expiration event* is stated. For Health Information Exchange authorizations, it is recommended to expire in at least five years.

_____
(Specify new date)

I understand that IHS will not condition treatment or eligibility for care on my providing this authorization except if such care is:
(1) research related or (2) provided solely for the purpose of creating Protected Health Information for disclosure to a third party.

I understand that information disclosed by this authorization, except for Alcohol and Drug Abuse as defined in 42 CFR Part 2, may be subject to redisclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act Privacy Rule [45 CFR Part 164] , and the Privacy Act of 1974 [5 USC 552a].

SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE *(State relationship to patient)*	DATE
SIGNATURE OF WITNESS *(If signature of patient is a thumbprint or mark)*	DATE

This information is to be released for the purpose stated above and may not be used by the recipient for any other purpose. Any person who knowingly and willfully requests or obtains any record concerning an individual from a Federal agency under false pretenses shall be guilty of a misdemeanor (5 USC 552a(i)(3)).

PATIENT IDENTIFICATION

NAME *(Last, First, MI)*	RECORD NUMBER
ADDRESS	
CITY/STATE	DATE OF BIRTH

The Navajo Nation ✧ Workers' Compensation Program ✧ P.O. Box 2489 Window Rock, Arizona
Phone: (928) 871-6389 ✧ Fax: (928) 871-6083

Release to Return to Work

Client's Name:_____ DOB:_____ SS#:_____

Date of Injury:_____ Claim Number:_____

Hospital/Clinic:_____ Date of Visit:_____

Diagnosis:_____

Contributing Factors (if any):_____

Prognosis:_____

Any probably permanent results? Yes ☐ No ☐

(Please check appropriate box and enter appropriate dates.)

☐Has the patient reached maximum therapeutic benefit yet? Yes ☐ No ☐ If not, when?_____

☐The patient has been examined and is able to return to work on_____(Date).

☐Due to injury/occupational disease, the patient is unable to return to work;
From_____To_____(Date).

☐The patient is able to return to work, but must perform only restricted duties;
From_____To_____(Date).

☐Restrictions included:_____

Lifting	☐ 00-10 lbs. ☐ 11-25 lbs. ☐ 26-50 lbs. ☐ 51 and over lbs.	Walking	☐ None ☐ 1-4 hours ☐ 4-6 hours ☐_____	Bending	☐ None ☐ Occasionally ☐ Frequently ☐_____	Carrying	☐ None ☐ Occasionally ☐ Frequently ☐_____	Driving	☐ None ☐ 1-4 hours ☐ 4-6 hours ☐_____

Return visit required on_____(Date) at_____AM/PM.

I certify that the above information reflects my professional opinion.

_____ _____

Physician's Name (please print) Physician's Signature (Date)