VACORP

Feb 2016

PORTSMOUTH PUBLIC SCHOOLS

WORKER'S COMPENSATION PANEL OF PHYSICIANS

I & O Medical Center
Michael Baddar, MD
James Alexander, MD
838 Old George Washington Hwy
Chesapeake, VA 23323
757-487-9600

1290 Diamond Springs Rd
Virginia Beach, VA 23455
757-460-0700

593 Aberdeen Rd.
Hampton, VA 23661
757-825-1100

Rozanne Dietzler, MD
732 Thimble Shoals Blvd.
Suite 102
Newport News, VA 23606
757-599-3623

Patient First
2425 Taylor Road
Chesapeake, VA 23321
757-215-1800
Jeanette Bender, PA
Pierce Gregory, MD
William Hubbell, MD

Specialists-Orthopaedic

Tidewater Orthopaedics
Loel Payne, MD
901 Enterprise Parkway
Hampton, VA 23661
757-827-2480

Atlantic Orthopaedic Specialists
Wilford Gibson, MD
230 Clearfield Avenue
Suite 124
Virginia Beach, VA 23462
757-321-3300

For therapy services ordered by the treating physician, contact Alignetworks at 1-866-389-0211.

THE CLOSEST EMERGENCY ROOM OR URGENT CARE FACILITY MAY BE USED DURING A MEDICAL EMERGENCY. ONCE EMERGENCY TREATMENT IS COMPLETE, A PANEL PHYSICIAN MUST BE CHOSEN FOR FOLLOW-UP CARE.

_______ I select _________________________ from the above panel.

_______ I decline to select a doctor from the above panel. I understand that I will have to pay for medical treatment and doctor bills, and that I may be denied worker's compensation benefits for any absence based on disability that is not certified by an approved physician.

___________________________ EMPLOYEE

______________________ DATE

Medical Authorization

I hereby authorize VACoRP, the insurer, or their representatives to be furnished with any and all information requested to include, but not limited to, medical records, diagnosis, treatment and prognosis, estimates of disability, and recommendations for further treatment. I further agree a photographic carbonless copy of this release shall be as valid as the original. This information is to be used for the sole purpose of evaluating and handling a Virginia Workers' Compensation claim resulting from the incident occurring on or about __________________ (date) and shall be used for no other purpose, now or in the future.

Employee Signature__________________________________ **Date**_______________________

To be completed by Attending Physician

Note to Physician: Please Fax Completed Form to VACORP at 877-212-8599

Employee Name ____________________

Employee Address ____________________

Name of Employer ________ Portsmouth Public Schools ________

Date of Accident/Injury ____________________ Date of Visit ____________________

Patient's account of how medical problem occurred ____________________

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Diagnosis ____________________

New Injury/Illness: Yes ☐ No ☐ Existing Condition: Yes ☐ No ☐

Did diagnosis result from patient's described onset: Yes ☐ No ☐ Unknown ☐

Physician comments ____________________

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Work Status

Return To Work Full Duties Yes ☐ No ☐ Date ____________________

Return To Work Modified Duties Yes ☐ No ☐ Date ____________________

List restrictions: ____________________

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Attending Physician (please print) ____________________ Phone ____________________

Physician signature ____________________ Date ____________________

Follow-up appointment with Date / Time ____________________