Treatment to be provided by: CONCENTRA

Medical Treatment Referral

(To be completed by Supervisor)

*All Submission Must Include the PMAMC Claim Number

Fax to PMAMC at 1-888-329-2721 or Email to claimsmail@pmagroup.com

Bills should be sent to:
PMAMC at P.O. Box 5231, Janesville, WI 53547-5231 or Email to claimsmail@pmagroup.com

Main Workers' Comp # 704-336-3021

Employer: Aviation-City of Charlotte ☐ CATS- City of Charlotte ☐ CDOT- City of Charlotte ☐ CLT Water-City of Charlotte ☐ CMPD-City of Charlotte ☐ Fire Dept.-City of Charlotte ☐ General Svcs & Fleet- City of Charlotte ☐ Solid Waste -City of Charlotte ☐ City of Charlotte -All other Depts ☐

Mecklenburg County ☐ MC Sheriff's Office ☐ Charlotte-Mecklenburg Schools ☐ MEDIC-EMS Agency ☐ CRVA ☐

Name of Employee:________________ Employee No.:________ Department: ________

Job Title:________________ Department: ________________

Date of Injury:__________ Time of Accident:__________ Date Accident Reported:__________

Who witnessed the accident? ________________ Vehicle Accident? *Yes* ☐ *No* ☐

Post-Accident Drug Screening: *Yes* ☐ *No* ☐ Alcohol Screening: *Yes* ☐ *No* ☐ DOT Alcohol/Drug Screen *Yes* ☐ *No* ☐

Was he/she working at their regular job at the time of the accident?________________

Is medical attention required? *Yes* ☐ *No* ☐ Emergency: *Yes* ☐ *No* ☐ Accident location:________________

Has previous treatment been received for this injury: *Yes* ☐ *No* ☐ Where:________________

Describe Incident and Injury:

I believe this event is job related and recommend that this individual seek initial medical care.

Supervisor's Signature________________Job Title__________Date________

Supervisor's printed name:________________Contact number:________________

Prescriptions and Driving

To be filled out by the Physician

Prescription Written/Received? *Yes* ☐ *No* ☐

Can the employee safely return to work, while taking this medication? *Yes* ☐ *No* ☐

For Driving Positions: Can the employee currently drive back and forth to work? *Yes* ☐ *No* ☐

Can the employee currently perform his/her driving position? *Yes* ☐ *No* ☐

Physician's Signature Date