MEDICAL REFERRAL

SUPERVISOR'S REPORT	To Medical (Location)	Date of Report	
Employee's Name	Time & Date of Injury	Time Left Job	Time Returned
Social Security Number	Grade, Rate, Job Title	Occupational Injury? ☐ Yes ☐ No ☐ Questionable	
Reason for Referral ☐ Injury ☐ Illness ☐ Return to Work ☐ Employee's Request ☐ Other (Specify below)			
Remarks:			
Supervisor's Signature	Shop/Office	Telephone Number	E-mail Address

MEDICAL REPORT	Time Reported	Time Released
Occupational Injury ☐ Yes ☐ No ☐ Questionable	Degree of Injury ☐ First Aid ☐ Medical Treatment ☐ Other (Explain below)	
Remarks:		
Provider's Signature	☐ Evaluation Completed ☐ Follow-up On or Before _____ Date	
Telephone Number		

Authority: SECNAVIST 5211.5D

Principle Purpose: To ensure prompt investigation of occupational injuries and to initiate any necessary immediate corrective action.

Routine Use: Routinely used by the activity Occupational Safety and Health Office to perform official duties in the investigation of mishaps which may have caused occupational injury or illness.

Disclosure: Voluntary. Treatment will be provided without regard to employee's willingness to divulge all or part of the requested information.