State of New York
WORKERS' COMPENSATION BOARD

Notice of Right to Select a Workers' Compensation Board Authorized Health Care Provider

Injured Employee's Name	Injured Employee's Social Security No.	Date of Accident
Employer's Name and Address		

To the Injured Employee:
For the treatment of your work-related injury or illness, you may choose any physician, podiatrist, chiropractor, or psychologist (upon referral from an authorized physician) who is Workers' Compensation Board authorized and who is accepting workers' compensation patients.

While you may choose to utilize a network or provider which is recommended by your employer or its workers' compensation insurance carrier or to permit your employer to select a provider on your behalf, you may, at any time, change your health care provider without jeopardizing your workers' compensation claim for benefits.

Signature of Injured Employee _____ Date _____ Signature of Witness _____ Date _____

Please note: It is not necessary for you to sign this consent form if your employer is (i) participating in a certified preferred provider organization (PPO) under Article 10-A of the Workers' Compensation Law, or (ii) participating in the alternative dispute resolution (ADR) pilot program under section 25(2-c) of the Workers' Compensation Law. In accordance with these statutory programs, except in emergency situations, you must obtain at least initial treatment for any workers' compensation injury or illness from the certified network(s) or providers designated by your employer.

To the Employer:
The employer shall provide the above-named injured employee with a copy of this signed form and shall maintain the original form in the employer's records where it may be inspected by the Workers' Compensation Board at any time. This form shall not be submitted to the Workers' Compensation Board nor shall it be executed prior to the occurrence of this employee's work-related injury or illness.

The Workers' Compensation Board employs and serves people with disabilities without discrimination.

Advanced Care Staffing
Employee Incident Report

Completed by the Injured Employee

Employee Name:_____ Employee SS#:_____ Date of birth:_____

Home Phone:_____ Cell Phone:_____

Date of Occurrence:_____ Time of occurrence:_____ AM/PM

What job duty was being performed when the accident occurred?

_____

_____

Were you working with a resident when this incident occurred? Yes____ No____

Were you working with another employee at the time of the incident? Yes___ No____

If yes, who was the other employee you were working with? _____

Please describe in detail the incident/accident that took place:_____

_____

_____

_____

What body part did you injury as a result of this occurrence?_____

My signature below indicates that the above statement is accurate and complete to the best of my knowledge. I grant Advanced Care Staffing the right to request and obtain, from any source, any and all medical information necessary to determine my health status pertaining to my work related injury, including but not limited to return to work evaluations and necessity and frequency of medical treatment.

_____ _____

Employee Signature Date

545 Broadway Suite 301 Brooklyn, NY 11206

Advanced Care Staffing
Employee Medical Release Form

I, _____, SS#_____
Print full name

hereby authorize Advanced Care Staffing and their authorized representatives to obtain any and all medical and diagnostic information and reports pertaining to my work related injury. This includes but is not limited to the return to work evaluation reports and all necessity and frequency of medical treatment inclusive of Independent Medical Exams. This also includes but not limited to current exemptions for information relating to New York State Workers' Compensation under the Health Insurance Portability and Accountability act, (HIPPA) this consent specifically covers any and all records and documents protected by any current statute or regulation.

A photocopy or fax of this authorization shall have the same force and effect as the original.

Employee Signature_____ Date:_____

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Advanced Care Staffing
Medical Care and Return to Work
Assessment Form

Patient:_____ Date of injury:_____

Treating Physician:_____ Job Title:_____

Diagnosis:_____ Date of treatment:_____

Patient is released to full duty as of _____ without restrictions: Yes No

Patient discharged from care: Yes No

Only complete the following if the patient has restrictions and is not released to full duty.

A. The patient can stand/walk: 1-4 hours_____ 4-8 hours_____ in a day.

B. The patient can sit: 1-4 hours_____ 4-8 hours_____ in a day.

C. The patient can lift: 11-20 lbs.____ 21-50 lbs._____ 50+ lbs.____ in a day.

D. Lifting as mentioned above can be done: Occasionally___ Frequently____

E. The right hand can be used for actions such as: Pushing___ Pulling___ Grasping___

F. The left hand can be used for actions such as: Pushing___ Pulling___ Grasping___

G. The patient is able to:

Bend	Occasionally___	Frequently___
Squat	Occasionally___	Frequently___
Kneel	Occasionally___	Frequently___

Estimated number of future visits until recovery is complete:_____ Next Visit:_____

Advanced Care Staffing offers temporary restricted duty to employees who are injured on the job.

Physician's Signature:_____

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