Work-Related Illness/Injury Form for Local Medical Providers

Dear Medical Provider,

We greatly appreciate your assistance regarding the care of our valued TE employees. We thrive to have an extremely safe work environment. Our employees represent our greatest asset. We expect outstanding medical care based on the best medical practice beyond the standard of care.

Our work-related injuries/illnesses are governed by OSHA Standards and Regulations. Majority of TE work related injuries/illnesses are minor and not considered OSHA recordable. We would like to minimize our OSHA recordable cases but keeping the medical care of our employees at the highest standards. For example, we would greatly appreciate consideration of OTC medications as much as feasible as well as soft splint instead of hard splints.

TE offers a comprehensive return to work program. We have modified duty available for all employees. When considering transitional work for our employees, we would accommodate restricted duty. We also avoid days away from work as much as possible. Whenever feasible an employee might be able to perform his/her regular duty despite the restrictions recommended by the medical provider.

A job description is included with this package for your review. Please consider it prior to assessing our employee.

We also recommend discussion of care with our Occupational Medical specialist KTA team. The KTA team e-mail is TECaseManagement@kta-md.com, and the phone number is (216) 504-0400. Again, thank you for your services and we look forward for our future collaboration to provide the best medical care for our workforce.

Sincerely,

TE Connectivity EHS Team

Dear Medical Provider:

You are authorized to render medical care including evaluation and treatment to the employee in accordance with TE Connectivity protocols and standards of medical care.

EMPLOYEE NAME:	
EMPLOYEE ID NUMBER:	
WORK AREA/DEPARTMENT:	
SUPERVISOR:	
SUPERVISOR PHONE NUMBER & E-MAIL:	
BRIEF DESCRIPTION OF THE INCIDENT:	
DIAGNOSIS:	
TREATMENT RENDERED ON-SITE:	
PLAN OF CARE:	
RETURN-TO-WORK WITH RESTRICTIONS:	
RETURN-TO-WORK AT FULL DUTY:	
COMMENTS/ADDITIONAL INSTRUCTIONS:	
NAME OF PROVIDER:	
PHONE NUMBER & E-MAIL OF PROVIDER:	

Medical Care Authorization Form

Clinic:

Date:

You are authorized to evaluate/render treatment to the employee named beelow in accorance with TE Connectivity 's safety protocols.

Employee Name:

Employee ID Number:

Work Area/Department:

Supervisor:

If Incident-Related: Brief description of incident or concerns

If Substance Abuse Testing:

- ☐ Random
- ☐ Probable Cause
- ☐ Post-Incident
- ☐ Alcohol Screen: ☐ Breath Alcohol ☐ Blood Draw (if for cause)

Comments/Additional Instructions:

If you have any questions, please call the facility Safety, Health, and Environmental/Mendical Representitive.

Sincerely,

INSERT EMPLOYEE JOB DESCRIPTION

Physical Capacities Evaluation

Please provide this form to employee to return to employer.

Patient's Name:		Job Title:	
Diagnosis:		Date of Service:	Time In:
			Time Out:

Doctor: *This form will be used to make determinations regarding your patient's ability to perform work-related activities. Please complete the following based upon your evaluation, the objective medical evidence and diagnosic test results. Please review the job description prior to completing this form, as an employee may be able to perform their regular job duties.*

Activity	**0**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**Special Instructions**
Sit:	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Stand:	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Walk:	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Drive Vehicles (Bus/Utility):	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Operate Machinery (Rail):	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	
Total hours patient can work	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	

The patient can perform these physical demands (please check all that applies)

	Never **0 hours**	**Rarely** **1-3 hours**	**Occasionally** **3-6 hours**	**Frequently** **6-8 hours**	**Continuously** **8+ hours**
☐ Lift ___lbs (indicate max. #)	☐	☐	☐	☐	☐
☐ Climb Stairs	☐	☐	☐	☐	☐
☐ Climb Ladders	☐	☐	☐	☐	☐
☐ Bend	☐	☐	☐	☐	☐
☐ Kneel	☐	☐	☐	☐	☐
☐ Squat	☐	☐	☐	☐	☐
☐ Crawl	☐	☐	☐	☐	☐
☐ Flex or extend neck	☐	☐	☐	☐	☐
☐ Simple Grasping	☐	☐	☐	☐	☐
☐ Fine Manipulation	☐	☐	☐	☐	☐
☐ Keyboarding	☐	☐	☐	☐	☐
☐ Can return to full duty - no restrictions	☐	☐	☐	☐	☐

These restrictions are TEMPORARY and will be reassessed on: ____________________________

Patient is able to return to full duty within 180 days: ☐ Yes ☐ No

Treatment Facility (please check): ☐ Occ Med ☐ Emergency Room ☐ Urgent Care

Was patient referred to a specialist? ☐ Yes ☐ No Next office visit date: ____________

Print Doctor's Name:	Doctor's Signature:
Telephone Number:	Employee's Signature:

I understand that by signing this form, I am agreeing to furnish a copy to my work location

Progress Update Form

TE Connectivity values its employees and their contributions; Therefore, TE strives to provide an injured or disabled employee the opportunity to return to temporary or transitional work (TW) as soon as his/her condition permits. Transitional Work allows an employee with temporary restrictions to work in a modified capacity on a temporary basis, while recuperating from an illness or injury. Constant update on the progress of the employee is crucial to the success of the program.

Please fill out the relevant sections below and submit them to KTA medical team.

Note: This form can also be filled out online at

*Date of Injury:	
*Date of TW assigned:	
*Date TW Agreement signed:	
Last visit with Treating physician:	
Updated restrictions:	
Update on Progress of employee:	
Is additional treatment needed?	
Is employee able to perform regular duty despite restrictions?	
Date of anticipated MMI:	
Date of anticipated exit from the TW	

*Should be completed by TE supervisor prior to sending out for updates.

TE CONNECTIVITY RECORD RELEASE FORM

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I, the below identified person, do hereby authorize the release of my medical information, as indicated herein, between the following parties:

FROM: ______________________________
____
____

TO: Kevin L. Trangle, MD, Josette Laklak, MD, & Amanda Hagen, MD
6150 Parkland Blvd., Suite 110
Mayfield Heights, OH 44124
Phone: 216-504-0400
Fax: 216-504-0404

I authorize this release of information to either [ ] verify services rendered to process a claim for benefits, [ ] to provide continuity to my medical care, [ ] at the request of the individual, [ ] other ___________________
____

I understand that the information I authorize a person or entity to receive may be redisclosed and no longer protected by Federal privacy regulations. I understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my ability to obtain treatment. I understand that this authorization shall remain in effect for sixty (60) days from the date of my signature below unless I specify an earlier expiration date in this space _____________. I understand, also, that except to the extent that action has been taken based on my authorization, I may withdraw this authorization at any time by written notification to the parties involved (see Notice of Privacy Practices).

- ☐ Face Sheet
- ☐ History & Physical
- ☐ Discharge Summary
- ☐ Consultation Reports
- ☐ Radiology Reports
- ☐ Laboratory Reports
- ☐ Operative Reports
- ☐ Pathology Reports
- ☐ Physician Progress Notes
- ☐ Physician Orders
- ☐ Therapy Reports
- ☐ Emergency Treatment
- ☐ Other specified here: ____________________
____
____

I am also making the following additional qualifications: **IF** the information specified above contains information related to treatment for drug and/or alcohol abuse or for psychiatric and/or mental conditions, or HIV test results or diagnosis, I **am** including this type of information to be released in association with this authorization.

__________ ______________________________ ______________________________
(Date) (Patient or Guardian Signature) (Witness)

To assist you, I am providing the following additional identifying information:

________________________ ____
(Print Name When Treated) (Address)

____________ ____
(Date of Birth) (City) (State) (Zip)

___________________ ____
(Social Security #) (Dates of Treatment)