Health Event Report

(Ref. WI 02.01.01.01.03 & WI 02.01.01.01.20)

Occupational Medicine Department (OMD) Pantex Plant
P.O. Box 30020, MS 12-2
Amarillo, TX 79120-0020
806-477-3049 – Case Management
806-477-5188 – Case Management FAX
806-477-3033 – Reception

Name: ______________________ Badge: __________ Dept: __________

Instructions to Individual:

Report off-site illness/injury, according to WI 02.01.01.01.20 whether or not you take sick time for it.

The purpose of this report is meeting your "fitness for duty", EPI reporting and HRP requirements.

NOTE: Failure to comply with HRP requirements risks your HRP status, if applicable. Loss of HRP status may affect your ability to perform assigned job duties.

Use this form **EVERY TIME** a health event happens as listed in WI 02.01.01.01.03 and/or WI 02.01.01.01.20. Bargaining personnel are also governed by their respective unit contracts.

Complete all entries in the "Affected Individual Section."

When you see a Healthcare Provider (doctor, therapist, clinician, dentist, etc.), make sure that they complete all entries in the section labeled "**Healthcare Provider Section**". **Employees cannot put information in this section because they are not healthcare providers. Doing so may result in discipline for falsification of records, up to and including termination.**

Go to the external website, www.pantex.com (on the main page), if you or your healthcare-provider need the form and don't have one at the time of your visit.

FAX or personally deliver the completed form to: Medical Case Management, Bldg. 12-2; FAX 806-477-5188

Privacy/HIPAA Information

By signing this form, the listed person authorizes his/her health care provider to disclose health information, as listed on the front of this form, to the Pantex Occupational Medicine Department. Applicable Federal law, State laws, and DOE Orders limit and protect disclosure of this information. This information is gathered for the purposes of determining the individual's fitness for duty in terms of his/her current position, for epidemiological tracking, and for benefits determination. Treatment and payment of health care services are not affected by not signing this form.

Any other use of this information without the written consent of the affected individual is prohibited. This consent may be revoked (in writing) at any time except to the extent that action has been taken in reliance on it. This consent expires 180 days after the latest date listed on the front of this form unless otherwise specified in writing.

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Affected Individual's Section:

Are you in the HRP? ☐ Yes ☐ No

Is this FMLA? ☐ Yes ☐ No

*If your condition has been approved for FMLA sick leave, please check the box above for FMLA

Person who was off work must complete all entries in this section. Sign your name on reverse side also; ***read instructions & HIPAA notice***

I authorize release of all medical information about this health event to the Pantex Occupational Medicine Department Case Managers to determine my fitness for duty related to my current position and for epidemiological tracking.

Print Your Name: *Please also print your name on the reverse side of this form*		Sign Your Name:	Badge#:
Dept #:	Job Title:	Supervisor's Name:	Supervisor's Phone#

Fill in the DATES & NUMBER OF HOURS you were off sick/injured. Information is for HRP & statistical use only.

	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Date(s) Off							
Hrs. Missed							

Reason for Report (Examples: off-site physical, dental work, cold, fever, other illness or injury, new medicine, etc.):

List any NEW or CHANGED medication taken as a result of this absence or write "NONE"

Did you go to a doctor, dentist or other healthcare provider? ☐ No ☐ **Yes: If YES, PROVIDER fills out bottom part.**

Healthcare Provider's Section – Employees can NOT fill in this section as they are not the healthcare provider.

Employees who write in this section may be subject to discipline up to termination for falsification of records.

HEALTHCARE PROVIDER, PLEASE COMPLETE ALL ENTRIES IN THIS SECTION.

Diagnosis:	
Operative/Dental Procedure:	Date of Treatment:
Medications:	

DATE that individual may return to work:	
List Restrictions (if any) Please consider posture, motion, lifting/carrying/driving, operating machinery and hours to be worked.	
	Follow-up Appt Date:

Print Healthcare Provider's Name:	Date/Time Of Visit: /
Healthcare Provider Signature & Title:	Telephone # With Area Code:

OFFICIAL USE ONLY
May be exempt from public release under the Freedom of Information Act (5 USC 552) exemption number and category:______
Department of Energy review required before public release.
______/B&W Pantex
Name/Organization
Date:______ Guidance ______

UNCLASSIFIED
When Form is Blank