

UAB ON-THE-JOB INJURY/ILLNESS PROGRAM

Initial Medical Evaluation Authorization

This form must be completed, signed and presented to the medical service provider prior to receipt of treatment, except in the event of a serious medical emergency.

This UAB employee, _____
Full Name of Employee *Social Security Number*

is referred to _____
Medical Service Provider for evaluation of the injury/

illness described below. An incident report must be completed and submitted as required by the OJI Program policy or refer to the [OJI Program](https://uab.edu/employeerelations) online at uab.edu/employeerelations

Employee's department: _____ Employee's position/title: _____

Date incident occurred: _____

Brief description of incident and resulting injury or illness:

Employee Signature: _____ Date signed: _____

Supervisor Signature: _____ Date signed: _____

Supervisor Phone Number: _____

Completion of this form does not certify that the injury or illness described above is an "on-the-job injury/illness" qualifying for benefits under the UAB On-the-Job Injury/Illness Program. An OJI Benefits Application* must be completed, signed and submitted to Acrisure as noted in the **How to Apply for OJI Benefits*** document.

***Forms can be accessed on the [Instructions and Forms for OJI](https://uab.edu/employeerelations) webpage at uab.edu/employeerelations under "On-the-Job Injury."**