



STATE OF NEW JERSEY

# SCHOOLS DEVELOPMENT AUTHORITY

## New Jersey Schools Development Authority – OCIP Site Treatment Authorization Form

Project/School Name: \_\_\_\_\_ NJSDA Contract #: \_\_\_\_\_  
 Contractor Name: \_\_\_\_\_ Employee Name: \_\_\_\_\_  
 Employer Contact: \_\_\_\_\_ Phone Number: \_\_\_\_\_  
 Date of Injury: \_\_\_\_\_ Time of Injury: a.m./p.m. \_\_\_\_\_  
 Signature of Injured: \_\_\_\_\_

**THIS COMPLETED FORM MUST BE RETURNED TO THE PROJECT BY THE  
EMPLOYEE SO HE/SHE CAN RETURN TO WORK**

This certifies that the above named individual is employed on the New Jersey Schools Development Authority OCIP Project. Workers Compensation coverage is provided through ACE USA. Please provide appropriate evaluation and treatment.

Site Approval Signature: \_\_\_\_\_

**THIS SECTION MUST BE COMPLETED BY THE ATTENDING PHYSICIAN**

Diagnosis: \_\_\_\_\_

1. Is the Employee able to return to work?  Yes  No

Full Duty: \_\_\_\_\_ Restricted Duty: \_\_\_\_\_ Total Disability: \_\_\_\_\_

If restricted duty was selected, briefly describe restrictions: \_\_\_\_\_

2. Will employee require any follow up treatment?  Yes  No

If yes was selected, when is the next scheduled visit?

Date: \_\_\_\_\_ Time: \_\_\_\_\_

Est. # of follow up visits: \_\_\_\_\_

3. I am aware of the restrictions placed on me by the treating Physician:

\_\_\_\_\_  
Employees' Signature:

\_\_\_\_\_  
Physicians' Name (Please Print)

\_\_\_\_\_  
Physicians' Signature