City of MEMPHIS

Notification of Emergency Treatment Form

(Supervisor/OSHA Coordinator completes form and employee signs prior to visit)

INITIAL TREATMENT/EMERGENCY: (Please select one facility)

Baptist Hospitals:
Memphis- 6019 Walnut Grove Rd 901-226-5000
Collierville- 1500 West Poplar Ave 901-861-9000

Methodist Hospitals:
3960 New Covington Pike - 516-5200 (North)
1300 Wesley Drive - 516-3700 (South)
7691 Poplar - 516-6418 (Germantown)
1265 Union - 516-7000 (University)

Regional Medical Center at Memphis Trauma Center: **(LIFE THREATENING TRAUMAS ONLY)**
877 Jefferson - 545-7100

St Francis Hospital:
Bartlett- 2986 Kate Bond Rd 820-7000
Main- 5959 Park Ave 765-1000

Facility Selected/Address:_____ **Employee Name:** _____

Type of Injury/Brief Facts: _____

DOI/Time:_____ **Division:** _____ **Department:** _____ **Job Title:** _____

Supervisor/OSHA Name/Signature: _____

It is a crime to knowingly provide false, incomplete or misleading information to any party to an on the job injury transaction for the purpose of committing fraud. Penalties include imprisonment, fines and denial of insurance benefits. Payments are not allowed for injury or claims stemming from, but not limited to falsifications of documents, and / or giving false statements. If you have questions, contact Workplace Safety at 901-636-6459. The Division has a Specialist that can provide assistance.

I understand and agree that in the event benefits are paid for charges incurred by an employee as a result of accidental bodily injury or disease sustained by such employee, the employee shall reimburse the City OJI Office to the extent of such benefit payments (1) out of any recovery (whether by settlement, judgement, or otherwise) made against any person or organization responsible for causing such injury or disease, and the City Workplace Safety Office shall have a lien upon any recovery received from such injury or disease; (2) but in no event shall such employee be required to make reimbursement in an amount exceeding the recovery received by him/her against the person or organization responsible for causing the injury or disease. I must notify the City's Workplace Safety Office, Third Party Administrator or the City Attorney's Office that a claim or lawsuit has been filed against the third party and/or the third party's insurance company within thirty days of the filing of said action. I agree by signature of this agreement that failure to notify the City of legal representation and/or acceptance of any settlement amount could result in the City's reimbursement being deducted from any wages/salaries.

Employee signature:_____ **Date:** _____

*Upon completion of form, Supervisor/OSHA Coordinator must immediately fax to Sedgwick via fax at (901)566-3415

*In the event of a catastrophic event or if the employee is transported to emergency room by ambulance, the Supervisor/OSHA Coordinator must complete this form per the above instructions

*Upon discharge from any emergency room visit, the employee must immediately follow-up with the applicable Supervisor/OSHA Coordinator regarding return to work instructions and TPA for follow-up care instructions

Updated 1/21/2019