MOHAWK
SELF INSURANCE

Safe Maternity Program MSI-4

SECTION A
Patient's Information

Patient's Name: _____ Home Telephone #:_____

Patient's Address: _____

Employer: _____ Telephone #:_____

SECTION B
Physician Information

Physician's Name: _____Telephone #:_____

Patient's Address: _____

Date of examination (M/D/Y):_____

Start date of leave (M/D/Y): _____

Pregnancy due date (M/D/Y):_____

Description of medical condition which necessitates preventative withdrawal or re-assignment.
Please identify known work hazards which may potentially harm the patient or the unborn baby.
What medical restrictions need to be considered in accommodating this worker in alternate work or modified duties?
How long will these medical restrictions be required?

I hereby authorize any hospital, physician, or other person who has attended me or the claimant to furnish to MSI or its representative's any and all information with respect to any illness or injury, medical history, consultations, prescriptions or treatment, and all copie all hospital or medical records, a photo copy of this authorization shall be considered as effective and valid as the original. I hereby authorize the release to M any information requested in respect of this claim. The furnishing of this form or its acceptance is not an admission of liability by MSI or a waiver of any condi of the coverage. MSI reserves the right to bring action to recover any benefit paid to an insured employee resulting from an accident caused by a third-party. beneficiary accepts to transfer all her/his rights to recover and authorize MSI to enforce such rights in her/his name.

Patient's Signature: _____ Date (M/D/Y): _____

Physician's Signature: _____ Date (M/D/Y): _____