MEDICAL RECORD - SUPPLEMENTAL MEDICAL DATA

For use of this form, see requiring document. Form is not valid without Requiring Document, Issuance Date, Local Form Number, and Edition Date.

REQUIRING DOCUMENT *(Title and Number)*		ISSUANCE DATE
OCCUPATIONAL HEALTH PROGRAM	NAVHOSPPNCLAINST 6260.2D	28 Dec 2011

LOCAL FORM TITLE *(Optional)*
INJURY NOTIFICATION

DATE: _____

From: (Medical Facility Initiating Report) _____

PART A - TO BE COMPLETED BY PATIENT OR PATIENT SURROGATE

Patient Name: _____

☐ Male ☐ Female DOB: _____

Command attached to: _____ Department: _____

Supervisor's Name and Phone Number: _____

Rank/Rate/Primary NEC or NOBC: _____ Civilian: Series/Grade: _____

☐ USN ☐ USMC ☐ USAF ☐ USA ☐ USCG ☐ Foreign ☐ DoD Civ ☐ NAF Civ ☐ PSC

Date and Time of Injury: _____ Place of Injury: _____

☐ On-Duty ☐ Off-Duty ☐ TAD

Brief explanation of what happened:

MILITARY: ***MUST INFORM YOUR SUPERVISOR OF ALL ON AND OFF DUTY MISHAPS.***
DoD CIVILIANS: ***MUST INFORM SUPERVISOR OF MISHAP AND COMPLETE CA-1 FORM. (www.dol.gov))***

PART B - PROVIDER REPORT

DIAGNOSIS: _____ Body Part Involved: _____

Extent of Disability: ☐ No Disability Likely ☐ Temporary ☐ Permanent Partial ☐ Permanent Total

Duty Status: ☐ Full Duty ☐ Light Duty # of days _____ ☐ Sent Home/SIQ # of days _____

What duty limitations are prescribed?

Did injury occur at work? ☐ Yes ☐ No

Occupational Health - place original in medical record; provide copy to the patient and forward copy to Safety within 24 hours

PRACTITIONER'S NAME	PRACTITIONER'S SIGNATURE	DATE
PATIENT'S IDENTIFICATION: *(For typed or written entries, give: Name - last, first, middle; SSN; Sex; Date of Birth; Rank/Grade.)*	HOSPITAL OR MEDICAL FACILITY	STATUS
	DEPARTMENT / SERVICE	RECORDS MAINTAINED AT
	SPONSOR'S NAME	SSN
	RELATIONSHIP TO SPONSOR	