



OFFICIAL USE ONLY
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Issue No. 026

Health Event Report

(Reference WI 02.01.01.01.03 and WI 02.01.01.01.20)

SECTION 1: EMPLOYEE ONLY:

Are you in the HRP? Yes No Were you hospitalized?
Is this FMLA Yes No Yes No

Complete all entries in this section. Print your name on the reverse side also; read instructions & HIPAA notice and Fax to: (806) 573-5188

I authorize release of all medical information about this health event to the Pantex Occupational Health Services Case Managers to determine my fitness for duty related to my current position and for epidemiological tracking.

Print Your Name:		Sign Your Name:		Phone #		Badge#:	
Dept. #:	Job Title:	Supervisor's Name:			Supervisor's Phone#		
<i>Fill in the DATES & NUMBER OF HOURS you were off sick/injured. Information is for HRP & statistical use only.</i>							
	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Date(s) Off							
Hrs. Missed							

Reason for Report (Examples: off-site physical, dental work, cold, fever, other illness or injury, new medicine, etc.):

List any NEW or CHANGED medication taken as a result of this absence or write "NONE"

Did you go to a doctor, dentist, or other healthcare provider? No Yes: If YES, PROVIDER fills out bottom part.

SECTION 2: HEALTHCARE PROVIDER ONLY

Employees can NOT fill in this section. Employees who write in this section may be subject to discipline up to termination for falsification of records. HEALTHCARE PROVIDER, PLEASE COMPLETE ALL ENTRIES IN THIS SECTION.

Diagnosis:	
Operative/Dental Procedure:	Date of Treatment:
Medications:	
DATE that individual may return to work:	
List Restrictions (if any) Please consider posture, motion, lifting/carrying/driving, operating machinery and hours to be worked.	
Follow-up Appt Date:	
Print Healthcare Provider's Name:	Date/Time Of Visit:
Healthcare Provider Signature & Title:	Telephone # With Area Code:

OFFICIAL USE ONLY May be exempt from public release under the Freedom of Information Act (5 USC 552) exemption number and category: _____ Department of Energy review required before public release. _____/CNS Pantex Name/Organization

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Health Event Report

(Reference WI 02.01.01.01.03 and WI 02.01.01.01.20)

Occupational Health Services (OHS) Pantex Plant
P.O. Box 30020, JCDC-N1
Amarillo, TX 79120-0020
806-573-3297 Case Management
806-573-5188 – Case Management FAX

E-mail: Nurse Case Management (Print) Name: _____ Badge: _____ Dept.: _____

Instructions to Individual:

Report off-site illness/injury, according to WI 02.01.01.01.20 **whether or not you take sick time for it.**

The purpose of this report is meeting your "fitness for duty," and Human Reliability Program (HRP) requirements.

NOTE: Failure to comply with HRP requirements risks your HRP status, if applicable. Loss of HRP status may affect your ability to perform assigned job duties.

Use this form **EVERY TIME** a health event happens as listed in WI 02.01.01.01.03 and/or WI 02.01.01.01.20. Bargaining personnel are also governed by their respective union contracts.

Complete all entries in Section 1.

When you see a Healthcare Provider (doctor, therapist, clinician, dentist, etc.), make sure that they complete all entries in the section labeled "**Healthcare Provider Section.**" **Employees cannot put information in this section because they are not healthcare providers. Doing so may result in discipline for falsification of records, up to and including termination.**

Go to the external website, [https://pantex.energy.gov\(on the main page\)](https://pantex.energy.gov(on the main page)), if you or your healthcare provider need the form and do not have one at the time of your visit.

FAX or personally deliver the completed form to: Medical Case Management, Bldg. JCDC-N1;
FAX 806-573-5188

Privacy/HIPAA Information

By signing this form, the listed person authorizes his/her health care provider to disclose health information, as stated on the front of this form, to the Pantex Occupational Health Services. Applicable Federal law, State laws, and DOE Orders limit and protect disclosure of this information. This information is gathered for the purposes of determining the individual's fitness for duty in terms of his/her current position, for epidemiological tracking, and for benefits determination. Treatment and payment of health care services are not affected by not signing this form.

Any other use of this information without the written consent of the affected individual is prohibited. This consent may be revoked (in writing) at any time except to the extent that action has been taken in reliance on it. This consent expires 180 days after the latest date listed on the front of this form, unless otherwise specified in writing.
