



Health Event Report

(Reference WI 02.01.01.01.03 and WI 02.01.01.01.20)

SECTION 1: EMPLOYEE ONLY:

Complete all entries in this section. Read instructions and Health Information Portability and Accountability Act (HIPAA) notice and Fax to: (806) 573-5188 or email to: nurse_case_management@pantex.doe.gov.

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

Print Name:		Signature:					
Badge #:	Dept. #:	Job Title:					
Supervisor's Name:		Supervisor's Phone Number:					
Fill in the DATES and NUMBER OF HOURS you were off sick/injured. Information is for Human Reliability Program (HRP) and statistical use.							
	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Date(s) Off							
Hours Missed							

Are you in the HRP? Yes No Is this Family Medical Leave Act (FMLA)? Yes No

Reason for Report (Examples: off-site physical, dental work, cold, fever, new medicine, other illness or injury, 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 MUST COMPLETE ALL ENTRIES IN THIS SECTION.

Diagnosis:	Date/Time of Treatment:	
Diagnosis Codes:	Follow-up Appt Date:	
Operative/Dental Procedure:	Was employee hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No	
Medications/Dosage:	DATE individual may return to work:	
Restrictions (if any) Please consider posture, motion, lifting/carrying/driving, operating machinery, and hours to be worked. _____ _____ _____		
Provider's Printed Name/Title:	Provider's Signature/Title:	Telephone #:



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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
nurse_case_management@pantex.doe.gov

Instructions to Employee:

Report off-site illness/injury, according to WI 02.01.01.01.20, *Reporting and Processing Off-the-Job Injury or Illness*, **whether or not you take sick time for it.**

This report meets the requirements of “fitness for duty” and HRP.

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, *Reporting and Processing On-the-Job Injury or Illness*, 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.**” **You cannot put information in this section because you are not the healthcare provider. 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.

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 Department of Energy (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.