

Attachment C:



UAB Health System Visitor/Student Authorization for Medical Evaluation

This form should be completed, signed and presented to the medical service provider prior to receipt of treatment, except in the event of a serious medical emergency. This form authorizes the provider to evaluate possible injuries that may have been sustained as a result of an event occurring on UAB Health System Facility premises. The UAB Health System Facility will be responsible for payment of PMD charges for initial evaluation and treatment of the injuries in the Emergency Department. This authorization for evaluation does not infer that the UAB Health System Facility is or will be responsible for payment of any charges for any other services. Furthermore, it must be understood this authorization for medical evaluation does not imply or expressly conclude the UAB Health System Facility and/or its staff contributed to or caused, directly or indirectly, the event that may have precipitated this one-time evaluation.

This Visitor/Patient (circle one), _____ (_____),
(printed full name and social security number)

is referred to _____ for evaluation.

Date alleged incident occurred: _____

Type of Incident (Check One):

- Fall
- Struck by object
- Puncture/laceration
- Other _____

UAB Health System Facility Representative Signature: _____

Printed Name & Title: _____

Telephone Number: _____ Date signed: _____

Occurred At: University Hospital UAB Academic Campus CEFH UAHSF/TKC Other _____
(Circle One)

ATTENTION EMERGENCY ROOM NURSE OR DOCTOR: You may contact the Office of Risk Management at 934-5382 or the Risk Manager on call through the UAB Call Center at 934-3411 for further information, if required. **DO NOT DELAY EMERGENCY MEDICAL CARE** to complete this forms process. It may be completed following the deliver of urgent medical interventions.

(V. 2/17/03)