ORU | MAKE NO LITTLE PLANS HERE

WORKERS' COMPENSATION REFERRAL FORM

Name of Medical Facility: _____

Dear Medical Provider,

Please be advised that this employee is authorized to receive initial care for a reported on-the-job injury and/or illness at Oral Roberts University. The incident will be investigated. This authorization is not an admission of liability or compensability under the Oklahoma Workers' Compensation Act.

Name of Employee: _____

Authorized by: _____

Immediate Supervisor or Departmental Manager

Authorizing Signature: _____ **Date:** _____

Department: _____

Phone: _____

Fax claims to:

Zurich Customer Care Center
PO Box 968017
Schaumburg, IL 60196
1-800-987-3373
Fax: 1-877-962-2567

If you have any questions, please contact Risk Management at (918) 495-7560.