



BUSINESS DEPARTMENT- Financial Services
 Risk Management Branch – Workers’ Compensation Office
 1515 Hughes Way, Long Beach, California 90810-1839
 (562) 997-8231 FAX (562) 997-8052

OCCUPATIONAL INJURY MEDICAL SERVICE ORDER
 (for approved medical facilities ONLY)

To: (Medical Facility) _____

Address: _____

Please give necessary medical care immediately to our employee named below in accordance with California workers’ compensation laws.

Employee _____ Social Security _____
 Date of Injury _____ Time of Accident _____
 Authorized by _____ Today’s Date _____
 (Manager/Supervisor)

IMPORTANT – PLEASE READ INSTRUCTIONS

Site Manager

1. Complete above section in full and send with employee.
2. Immediately report by telephone to Risk Management Branch any injury such as loss of members or limbs, or requiring hospitalization, or incident involving 5 or more employees.

Medical Facility

1. Our self-insurance administrator is **Tristar Risk Management**. Tristar can be reached at (562) 506-0300. Fax number (562) 981-0804
2. Mail to Tristar Risk Management, P. O. Box 2805, Clinton, IA 52723-2805 the following:
 - a) Original and one copy of “Doctor’s First Report of Occupational Injury/Illness”
 - b) Original and one copy of subsequent or supplemental report
 - c) All invoices in duplicate
3. Mail confidentially to employer, Long Beach Unified School District, Risk Management Branch, 1515 Hughes Way, Long Beach, CA 90810, the following:
 - a) One copy of “Doctor’s First Report of Occupational Injury/Illness”
 - b) One copy of each subsequent or supplemental report.