Employee Health Report

Fax Employee Health Reports to (918) 977-8107. Fax all other medical documents to clinic fax numbers on page 2.

Section 1: Employee Completes Entire Section (Please Print)

ALL INFORMATION IS CONFIDENTIAL
Fax Completed Form To
918-977-8107

Employee Information and Consent

Employee Name (Last, First, MI)		Employee ID Number (Must be 8 digits)		
Employee Address, City, State, Zip		Business Unit		Employee Home Phone Number
First Day of Injury/Illness	First Day Missed Work	Is this a Work Place Injury/Illness? ☐ Yes ☐ No	Supervisor Notified? ☐ Yes ☐ No	Employee Home Email Address

I hereby authorize the undersigned **Licensed Health Care Professional** (**LHCP**) to release information to or to discuss with a Phillips 66 LHCP, or a Phillips 66 Absence Management Representative, any information regarding this injury or illness (continued next page).

Employee Signature	Date Signed:
X	

ATTENTION LHCP: Phillips 66 promotes a TRANSITIONAL DUTY PROGRAM.
Please complete ALL the information below concerning the employee's work status.

Section 2: Health Care Provider Use Only: (Please Print)

Work Status

Is this absence due to a mental health condition? ☐ **Yes** ☐ **No**
If yes, please request an EHR Supplemental form from Phillips 66 HR Connections at: 855-480-6634 or 918-977-7905

Date of Most Recent Visit:	Date of Next Appointment:	Estimated Return to Work – Full Duty:	Estimated Return to Work Modified Duty:

Patient may work:
- ☐ Full Duty/No Restrictions. RTW date:_____
- ☐ Is incapacitated/unable to perform essential functions of job in any manner. Estimated RTW date:_____
- ☐ Modified Duty – Full Days *(check capacities below).* RTW date:_____
- ☐ Modified Duty – Limited Hours -_____hours/day *(check capacities below).* RTW date:_____

Patient Progress:
- ☐ Treatment concluded. Maximum Medical Improvement (MMI) attained ☐ As Expected
- ☐ Better than Expected ☐ Worse than Expected
- ☐ Current Rehab: ☐ PT ☐ OT ☐ Home Exercise ☐ Other (e.g. activity coaching) _____

Medical Condition Information

Description of medical condition, symptoms and other medical facts for which patient is being treated:	ICD10 Code(s) (If permitted by state standards)

Overnight Hospital Stay or Surgery? ☐ Yes ☐ No	**Dates of Hospitalization or Surgery**	**Reason for Hospitalization or Surgical Procedure**

Current Medications or Other Treatment (i.e. counseling, physical therapy) AND Frequency

Complications impeding recovery? ☐ Yes ☐ No	**Describe Complications:**

CAPACITIES: Estimate what the patient can do at work and home

How long are the patient's current capacities expected to apply? **(estimate)**
☐ 1-10 days ☐ 11-20 days ☐ 21-30 days ☐ 30+ days ☐ Permanent
Capacities apply all day, every day of the week, at home as well as at work.

Patient can perform the following: (only check motions that apply) ***A blank space indicates = No Restriction***		**Never** 0 hours	**Seldom** 0-1 hour	**Occasional** 1-3 hours	**Frequent** 3-6 hours	**Constant** Not Restricted
Sit (desk work on the job)		☐	☐	☐	☐	☐
Stand / Walk		☐	☐	☐	☐	☐
Climb Stairs / Ladders / Work at Heights (circle appropriate activity)		☐	☐	☐	☐	☐
Twist / Bend / Stoop (circle appropriate activity)		☐	☐	☐	☐	☐
Squat / Kneel / Crawl (circle appropriate activity)		☐	☐	☐	☐	☐
Operate Motor Vehicle, Heavy Vehicles or Machinery		☐	☐	☐	☐	☐
Reach / Work above shoulders	**L**eft **R**ight **B**oth	☐	☐	☐	☐	☐
Use Computer / Keyboard	**L R B**	☐	☐	☐	☐	☐
Wrist / Elbow / Shoulder (flexion/extension)	**L R B**	☐	☐	☐	☐	☐
Grasp (forceful)	**L R B**	☐	☐	☐	☐	☐
Operate foot controls	**L R B**	☐	☐	☐	☐	☐
Lift / Push / Carry	**L R B**	_____lbs.	_____lbs.	_____lbs.	_____lbs.	_____lbs.
Must use Assistive Devices **(List Device Type):**	**L R B**	☐	☐	☐	☐	☐

LHCP INFORMATION – Please list your title as a Licensed Health Care Provider (i.e. MD, DO, DC, PA, ARNP, LPT, DDS, etc.)
Please provide all requested information - Attach further comments/notes as needed to support patient's absence.

LHCP Signature			Address:
LHCP Name – (print)			
Date Signed	Phone: ( )	Fax: ( )	

Additional Consent Information

I understand that this authorization is voluntary and may be revoked at any time. I also understand that my failure to provide authorization could affect my eligibility for short-term disability benefits under the Phillips 66 Disability Plan. This authorization will remain in effect no longer than 60 days from the date of the licensed health care provider's signature.

I have read and understand the following statements about my rights:

- I may revoke this authorization at any time prior to its expiration date by notifying the providing organization in writing, but the revocation will not have any effect on any actions the entity took prior to its receipt of the revocation.
- I may request a copy of the records or other information provided by my LHCP to Phillips 66.
- Receipt of health care benefits under the Phillips 66 Medical and Dental Assistance Plan is not contingent upon my signing this form.

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by law. To comply with GINA, we are asking that you not provide any genetic information when responding to this request for medical information. 'Genetic information' as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

Fax/E-mail Information

Employee Health Reports may be faxed or emailed to the following:	
Fax: 918-977-8107	Email: ImageEHR@p66.com

Phillips 66 Clinic Information

All other medical documents should be faxed to the appropriate clinic below

Phillips 66 Health Services Alliance Refinery 15551 Hwy 23 South P.O. Box 176 Belle Chasse, LA 70037 Phone: 504-656-3299 Fax: 504-656-3407	Phillips 66 Health Services 411 S. Keeler Ave. AB-02-232 Bartlesville, OK 74003-6670 Phone: 918-977-6001 Fax: 918-977-8005	Phillips 66 Health Services Phillips Research Center 87D-01-189A Bartlesville, OK 74003-6670 Phone: 918-977-7334 Fax: 918-977-9895
Phillips 66 Health Services Bayway Refinery 1400 Park Ave. Linden, NJ 07036 Phone: 908-523-6290 Fax: 908-523-5215	Phillips 66 Health Services Billings Refinery 401 South 23rd Street Billings, MT 59101 Phone: 406 255 2542 Fax: 918-977-8005	Phillips 66 Health Services Borger Refinery P.O. Box 271 Borger, TX 79008 Phone: 806-275-1502 Fax: 806-275-1932
Phillips 66 Health Services Ferndale Refinery P.O. Box 8 3901 Unick Road Ferndale, WA 98248 Phone: 360-384-8329 Fax: 360-384-8465	Phillips 66 Health Services 2331 City West Blvd. HQ-02-S240 Houston, TX 77042 Phone: 832-765-1400 Fax: 832-765-0113	Phillips 66 Health Services Lake Charles Mfg. Complex 2200 Old Spanish Trail Westlake, LA 70669 Phone: 337-491-5075 Alt Phone: 337-491-5162 Fax: 337-491-5047
Phillips 66 Health Services Los Angeles Refinery 1660 W. Anaheim St. Wilmington, CA 90744 Phone: 310-952-6037 Fax: 310-952-6033	Phillips 66 Health Services Ponca City Refinery 1000 S. Pine Ponca City, OK 74602 Phone: 580-767-6360 Fax: 580-767-2006	Phillips 66 Health Services Rodeo Refinery 1380 San Pablo Ave. Rodeo, CA 94572 Phone: 510-245-4468 Fax: 510-799-6486
Phillips 66 Health Services Santa Maria Refinery 411 S. Keeler Ave. Bartlesville, OK 74003-6670 Phone: 918-977-6001 Fax: 918-977-8005	Phillips 66 Health Services Sweeny Refinery P.O. Box 866 Sweeny, TX 77480 Phone: 979-491-2391 Fax: 979-491-2440	Phillips 66 Health Services Wood River Refinery 900 S. Central Ave. P.O. Box 76 Roxana, IL 62084 Phone: 618-255-2308 Fax: 618-255-3097