PHYSICIAN’S REPORT OF WORKER’S COMPENSATION INJURY
A COPY OF THIS REPORT MUST BE SENT TO THE INJURED WORKER AND THE INSURER.

1. REPORT TYPE  □ Initial  □ Progress  □ Closing

2. CASE INFORMATION
   Date of Injury
   Injured Worker
   Social Security #
   Date of Birth

3. INITIAL VISIT (only)
   a. Insured worker’s description of accident/injury

   b. Are your objective findings consistent with history and/or work-related mechanism of injury/illness? □ Yes  □ No

4. CURRENT WORK STATUS  □ Working  □ Not Working

5. WORK-RELATED MEDICAL DIAGNOSIS(ES)

6. PLAN OF CARE
   a. TREATMENT PLAN
      □ Diagnostic tests/tests
      □ Procedures
      □ Therapy
      □ Medications
      □ Supplies

   b. WORK STATUS
      □ Able to return to full duty on
      □ Able to return to modified duty from
      □ Unable to work from
      □ Able to return to part time work on

   c. LIMITATIONS/RESTRICTIONS
      □ Lifting (maximum weight in pounds)
      □ Repeating lifting
      □ Carrying
      □ Pushing / Pulling
      □ Paching / Grapping
      □ Reaching over head
      □ Reaching away from body

7. FOLLOW UP CARE AND REFERRALS
   a. □ Return Appointment Date
   b. □ Referral for □ Treatment (specify) □ Evaluation (specify)
      □ Referral to Provider’s Name
      □ Phone #
      □ Discharged for Non-Compliance □ Discharged from Care for Nonmedical Reasons

8. MAXIMUM MEDICAL IMPROVEMENT (MMI)
   □ Injured Worker has reached MMI
   □ Injured Worker is not at MMI but is anticipated to be at MMI in/on
   □ MMI date unknown at this time because

9. MAINTENANCE CARE AFTER INJURY
   If yes, specify care:

10. PERMANENT MEDICAL IMPAIRMENT (REQUIRED)
    □ No permanent impairment
    □ Permanent impairment (attached required worksheets and narrative)
    □ Anticipate permanent impairment
    □ Needs referral to Level II physician for impairment rating (see 7b above)

11. PHYSICIAN’S SIGNATURE __________________________ Date of Report __________
    Print Name __________________________ License # __________________________ Phone # __________________________