

ATTENDING PHYSICIAN'S INITIAL REPORT OF INJURY AND TREATMENT

INSTRUCTIONS TO PHYSICIAN: *This initial report should be completed and mailed within 20 days, the original to the Administrator (See item 13 for address), with a copy to the Company in item 14. Subsequent reports should be made regularly on Form WCC-201 or in narrative form while employee is in your care. Please read item 9 on the front of this form..*

15. What history of injury or disease did Employee give to you?

16. Is there any history or evidence of PRE-EXISTING injury, disease or Physical impairment? No Yes

17. What are your findings?

18. What is your diagnosis?

19. Do you believe the condition found was CAUSED or AGGRAVATED by the employment activity described?

Yes No (*Please explain if there is*)

20. Did injury require hospitalization? No Yes

Hospital:

Admission Date:

Discharge Date:

21. Is additional hospitalization required?

No Yes

22. Surgery (if any, describe):

Date performed:

23. Other types of treatments:

24. What PERMANENT DEFECTS do you anticipate?

25. Date of first examination:

26. Date of Treatments:

27. Dates of discharge:

28. Period of TEMPORARY DISABILITY (*Indicate if unknown*)

Partial Disability: From _____ To _____

Total Disability: From _____ To _____

29. Date Employee able to resume work.

LIGHT REGULAR

30. If Employee is able to resume work, date when advised:

31. If Employee is able to resume only light work, indicate extent of PHYSICAL LIMITATIONS and type of work that could reasonably be performed with limitations:

32. General remarks and RECOMMENDATIONS for future care, if indicated:

33. Do you SPECIALIZE? No Yes (*Specify*)

34. Name and Signature of Physician:

35. Address:

36. Date of Report:

37. MEDICAL BILL (Charges for your services may be presented in the space below or on your billhead).

Date of Treatment	Service/Supplies MUST be itemized	Quantity	Unit Price	Amount