Department of Commerce

WORKERS' COMPENSATION COMMISSION
COMMONWEALTH OF THE NORTHERN MARIANA ISLANDS
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WCC FILE #: ____________

CARRIER'S #: ____________

EMPLOYER'S #: ____________

PHYSICIAN'S REPORT FOR SUBSEQUENT TREATMENT

INSTRUCTIONS: *This form is to be used for subsequent treatment, to make progress reports and final report when the patient is discharged. Aft questions must be answered fully. Write "NA" if not applicable. The exact point of amputation and other permanent. partial disabilftles must be known in order to determine compensation due the injured employee accordng tothe PPD schedule provided by law. The back of this form may be used if needed The physician may submit a narrative report covering all the questions and information asked for in this form on separate sheets. This report is required by 4 CMC 9307(a).*

1. Name of injured employee:

2. Date of injury:

3. Employee's address:

4. Date of Birth (Mo/Da/Yr)

5. Sex:

6. Name of Employer:

7. Employer's Address:

8. Date first visit:

9. Date of discharge:

10. Who authorized treatment?

11. Nature of treatment:

12. Dates of your treatment:

13. Was employee hospitalized? ☐ Yes ☐ No
(If yes, respond in item 15).

14. Were X-rays taken? ☐ Yes ☐ No
(If yes, give result in #17)

15. Give names, addresses, and dates of treatments provided by hospitals or other doctors for this injury:

16. Employee's account of how injury or exposure to occupational disease occurred:

17. Finds upon examination (Include results of X-rays, laboratory studies, etc. Note prior injuries and existing conditions and any remarks and recommendations on the reverse side of this form).

18. Diagnosis:

19. Is diagnosed condition due to occurrence described in item 16? (If no, explain on reverse side of this form) ☐ Yes ☐ No

20. Was there disability for work?
☐ Yes ☐ No If yes, answer >>>

A. Date disability began:

B. Date able to return to light work

C. Date able to return to regular work:

21. Will there be permanent defect, or facial or head disfigurement? If yes. describe briefly and estimate loss in % terms.
☐ Yes ☐ No

22. Name of attending physician:

23. Address:

24. Signature of physician

25. Date of this report: