PHYSICIAN'S REPORT OF EMPLOYEE INJURY
TO BE COMPLETED BY APPROVED PROVIDER

Please be advised Workers' Compensation insurance is not carried by the Employer of this Employee. All bills for authorized medical treatment or any inquiries concerning authorization for treatment or payment should be directed to:

Name _____ Contact _____

Address _____ Phone Number (_____) _____ - _____

1. Name of injured employee: _____ S.S. #: _____ - _____ - _____
   DOB: _____/_____/_____ Home address: _____ Apt #: _____
   City: _____ State: _____ Zip: _____
2. Date of accident: _____/_____/_____ Date first treatment rendered: _____/_____/_____
3. Cause of injury: _____
4. Initial complaints: _____
5. Nature, extent, degree, body location of injury: _____
6. Treatment prescribed: _____
7. If admitted to hospital, name & address: _____
8. Probable length of hospital confinement: _____
9. X-rays taken? ____Yes _____No Describe procedure and results: _____
10. Lab test? _____Yes _____No Describe procedure and results: _____
11. Was there any evidence of a prior or pre-existing injury or illness? _____ Yes _____No
    If yes, what condition and to what extent may it contribute to incapacity or recovery? _____
12. Released to restricted duty: _____/_____/_____ Specify restrictions: _____

    Released to Regular Duty: _____/_____/_____ If not released, estimated length of disability:

    Name of Physician: _____

    Address: _____

    Signature: _____ Date: _____/_____/_____

Send this form with injured employee to your medical provider.