Commonwealth of Massachusetts
Human Resources Division

Workers' Compensation Section
One Ashburton Place, 3rd Floor
Boston, MA 02108
PHYSICIAN'S REPORT

Report status: Initial_____Follow-up _____

TO BE COMPLETED BY EMPLOYER:

1. Name of Facility/Agency_____phone:(_____)-_____
   Address: _____
   Name/Title of Workers' Compensation Contact: _____

TO BE COMPLETED BY EMPLOYEE:

2. Full Name _____Date of Birth: ___/___/___
   First Middle Last
   Address:_____
3. Date of Injury: _____Social Security No.: _____-_____-_____
4. Has employee received prior medical treatment for this injury? Yes_____ No_____
   If yes, by whom?_____

TO BE COMPLETED BY MEDICAL PROVIDER/OFFICE STAFF:

5. Practice Name: _____
6. Physician Name (print or type): _____ Date of Exam___/___/____
   License No.:_____Specialty:_____Date of Report___/___/____
7. Mailing Address: _____
8. Phone Number: (_____)-_____ Fax Number: (_____)-_____

TO BE COMPLETED BY PHYSICIAN (MEDICAL EXAMINATION RESULTS):

9. Provide patient's statement as to how the injury occurred: _____
   _____
10. Is there a history/evidence of pre-existing injury/disease: Yes _____ No_____
    If yes, explain:_____
11. Subjective Complaints: _____
    _____
12. Objective Findings: _____
    _____
13. Neurological Findings (if any): _____
    _____
14. Diagnosis:_____
15. Plan of Treatment:_____
16. In your opinion, was the accident/exposure a producing/contributing cause of the injury? Yes___ No____
17. Is the employee able to perform his/her regular work duties? Yes____ No____
    If no, employee may return to full duty in _____days/weeks. (Circle one)

18. ***FUNCTIONAL LIMITATIONS***:
    Temporary modified work may be available at state facilities. The employer may develop a modified job based on any restrictions described below. Patient ***CANNOT:***

SIT	more than _____hours/day
STAND/WALK	more than _____hours/day
CARRY/LIFT	more than ___10___20___30___40___50___lbs.
PUSH	more than ___10___20___30___40___50___lbs.
PULL	more than ___10___20___30___40___50___lbs.
DRIVE VEHICLE	Yes_____ No_____
OTHER (please describe):	_____

19. (Physician Referrals Only) Indicate Physician: _____Specialty: _____

SIGNATURE OF PHYSICIAN

I certify under the pains and penalty of perjury that I have personally examined the above named employee.
Signature:_____Date:_____
(I am a duly licensed physician)