Workers' Compensation Section One Ashburton Place, 3 <sup>rd</sup> Floor Boston, MA 02108 PHYSICIAN'S REPORT Report status: InitialFollow-up TO BE COMPLETED BY EMPLOYER:	Ca	Human Resources	<sup>3</sup> Division	
One Ashburton Place, 3 <sup>rd</sup> Floor Boston, MA 02108 PHYSICIAN'S REPORT         Report status: InitialFollow-up				
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PHYSICIAN'S REPORT         Report status: InitialFollow-up         Report status: InitialFollow-up         Address:				
Report status: InitialFollow-up				
TO BE COMPLETED BY EMPLOYER:		PHYSICIA		
1.       Name of Facility/Agency	тор	E COMDI ETER BY EMBLOYER.	Report status: InitialFollow-up	
Address:			nhone:()-	
TO BE COMPLETED BY EMPLOYEE:         2.       Full Name		Address:	p.no.no.()	
TO BE COMPLETED BY EMPLOYEE:         2.       Full Name		Name/Title of Workers' Compensation Contact:		
2.       Full Name	TO B	E COMPLETED BY EMPLOYEE:		
Address:         3.       Date of Injury:       Social Security No.:         4.       Has employee received prior medical treatment for this injury?       Yes			Date of Birth://	
3.       Date of Injury:			idle Last	
4. Has employee received prior medical treatment for this injury?       Yes No	2		Control Construction Man	
If yes, by whom?		Has employee received prior medical treatment f	for this injury? Ves No	
TO BE COMPLETED BY MEDICAL PROVIDER/OFFICE STAFF:         5.       Practice Name:         6.       Physician Name (print or type):         License No.:       Specialty:         7.       Mailing Address:         8.       Phone Number:         9.       Provide patient's statement as to how the injury occurred:         10.       Is there a history/evidence of pre-existing injury/disease: Yes       No	т.			
5.       Practice Name:         6.       Physician Name (print or type):				
6.       Physician Name (print or type):				
7.       Maining Address:         8.       Phone Number; (		Physician Name (print or type):	Date of Exam / /	
7.       Maining Address:         8.       Phone Number; (		License No.:Specialty:	Date of Report / /	
TO BE COMPLETED BY PHYSICIAN (MEDICAL EXAMINATION RESULTS):         9. Provide patient's statement as to how the injury occurred:		Mailing Address:		
9.       Provide patient's statement as to how the injury occurred:	8.	Phone Number: ()	Fax Number: ()	
If yes, explain:				
11.       Subjective Complaints:         12.       Objective Findings:         13.       Neurological Findings (if any):         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	10.			
12.       Objective Findings:	11.	Subjective Complaints:		
<ul> <li>13. Neurological Findings (if any):</li></ul>	12.	Objective Findings:		
<ul> <li>15. Plan of Treatment:</li></ul>	13.	Neurological Findings (if any):		
<ul> <li>15. Plan of Treatment:</li></ul>	14.	Diagnosis:	· · · ·	
<ul> <li>16. In your opinion, was the accident/exposure a producing/contributing cause of the injury? YesNo</li> <li>17. Is the employee able to perform his/her regular work duties? YesNo</li> <li>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 <u>CANNOT:</u> SIT</li></ul>		Plan of Treatment:		
If no, employee may return to full duty indays/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 <u>CANNOT:</u> SIT		In your opinion, was the accident/exposure a producing/contributing cause of the injury? YesNo		
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 thanhours/day         STAND/WALK       more thanhours/day         CARRY/LIFT       more than1020304050lbs.         PUSH       more than1020304050lbs.         PULL       more than1020304050lbs.         DRIVE VEHICLE       YesNo         0THER (please describe):	17.			
Temporary modified work may be available at state facilities. The employer may develop a modified job based on any restrictions described below. Patient <u>CANNOT:</u> SIT       more thanhours/day         STAND/WALK       more thanhours/day         CARRY/LIFT       more than1020304050lbs.         PUSH       more than1020304050lbs.         PULL       more than1020304050lbs.         DRIVE VEHICLE       YesNo         OTHER (please describe):		If no, employee may return to full duty in	days/weeks. (Circle one)	
Temporary modified work may be available at state facilities. The employer may develop a modified job based on any restrictions described below. Patient <u>CANNOT:</u> SIT       more thanhours/day         STAND/WALK       more thanhours/day         CARRY/LIFT       more than1020304050lbs.         PUSH       more than1020304050lbs.         PULL       more than1020304050lbs.         DRIVE VEHICLE       YesNo         OTHER (please describe):	18	FUNCTIONAL LIMITATIONS.		
based on any restrictions described below. Patient <u>CANNOT:</u> 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. PULL more than 10 20 30 40 50 lbs. DRIVE VEHICLE Yes No OTHER (please describe): 19. (Physician Referrals Only) Indicate Physician: Specialty: I certify under the pains and penalty of perjury that I have personally examined the above named employee. Signature: Date:			ate facilities. The employer may develop a modified job	
STAND/WALK       more thanhours/day         CARRY/LIFT       more than1020304050lbs.         PUSH       more than1020304050lbs.         PULL       more than1020304050lbs.         DRIVE VEHICLE       Yes No         OTHER (please describe):				
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       0       0       0       0       0       lbs.         19.       (Physician Referrals Only) Indicate Physician:		SIT		
PUSH       more than1020304050lbs.         PULL       more than1020304050lbs.         DRIVE VEHICLE       YesNo         OTHER (please describe):				
PULL       more than 10 20 30 40 50 1bs.         DRIVE VEHICLE       Yes No         OTHER (please describe):			more than $10 20 30 40 50$ lbs.	
DRIVE VEHICLE       YesNo         OTHER (please describe):			more than $10 20 30 40 50$ lbs.	
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:		OTHER (please describe):		
SIGNATURE OF PHYSICIAN I certify under the pains and penalty of perjury that I have personally examined the above named employee. Signature: Date:	19.	(Physician Referrals Only) Indicate Physician:	Specialty:	
Signature: Date:		ATURE OF PHYSICIAN		
(I am a duly licensed physician)				
			Date	

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