Human Resources Division
Workers' Compensation Section
100 Cambridge Street, Suite 600
Boston, MA 02114

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. Physician Name (print or type):_____Date of Exam____/___/____
   License No.:_____Specialty:_____Date of Report___/___/____
6. Mailing Address:_____

TO BE COMPLETED BY PHYSICIAN(MEDICAL EXAMINATION RESULTS):

7. Provide patient's statement as to how the injury occurred:_____
   _____
8. Is there a history/evidence of pre-existing injury/disease: Yes _____ No_____
   If yes, explain:_____
9. Subjective Complaints:_____
   _____
10. Objective Findings:_____
    _____
11. Neurological Findings (if any):_____
    _____
12. Diagnosis:_____
13. Plan of Treatment:_____
14. In your opinion, was the accident/exposure a producing/contributing cause of the injury? Yes___ No____
15. 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)

16. ***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):	_____

17. (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)