DEPARTMENT OF CONSUMER & BUSINESS SERVICES — *Workers' Compensation Division*

Worker's and Physician's Report for Workers' Compensation Claims

WCD employer no.:	
Policy no.:	

Note to Physician or Nurse Practitioner: **Ask the worker to complete this form ONLY for the three filing reasons in the worker's section; do not have the worker complete or sign form if this is a progress report or palliative-care request.**

Dept. Use — Ins. no. / Occ. / Nature / Part / Event / Source / Assoc. object

Worker or physician

Worker's legal name, street address, and mailing address:

Phone:

Worker's language preference: ☐ English ☐ Spanish ☐ Russian ☐ Vietnamese ☐ Other (please specify):

Claim no. (if known):

Social Security no. (see back of form):

Date of birth:

Male/female ☐ ☐

Date/time of original injury:

Employer at time of original injury — name and street address:

Phone:

Occupation:

Last date worked:

Workers' compensation insurer's name, address:

Worker

Worker: Check reason for filing this form, answer questions (if any), and sign below.

☐ **First report of injury or disease** (Do not complete or sign if you do not intend to make a claim.)
Has the same body part been injured before? ☐ Yes ☐ No (If yes, describe when and how.)
By my signature I authorize the use of my SSN as described in paragraph 2 on the back. If you do not authorize use of your SSN as described in paragraph 2 on back, check here ☐.

Check here if you have more than one employer. ☐

Describe accident:

☐ **Report of aggravation of original injury**

☐ **Notice of change of attending physician or nurse practitioner**

Reason for change:

By my signature I am giving **NOTICE OF CLAIM or CHANGING MY ATTENDING PHYSICIAN OR NURSE PRACTITIONER.** I authorize medical providers and other custodians of claim records to release relevant medical records. I certify that the above information is true to the best of my knowledge and belief. (See #s 3 and 4 on back.)

X

Worker's signature **Date**

Physician

Physician: If worker initiated this report, give worker a copy immediately.

☐ **First report of injury or disease** (Mail this form to the workers' compensation insurer within 72 hours of visit.)

☐ **Change of attending physician or nurse practitioner** (I accept responsibility for the care and treatment of the above named worker.)

☐ Prior medical records have been requested from the previous attending physician or nurse practitioner.

☐ **Insurer is hereby requested to send its records.**

☐ **Progress report** *OR* ☐ **Closing report** (See instructions in Bulletin 239.)

☐ **Aggravation; actual worsening of underlying condition** (Mail 827 signed by attending physician to insurer within five days of visit.)

☐ **Palliative care request** — Complete remainder of form, except Section b. (Worker must be currently employed or in vocational training to be eligible.) Attach a palliative care plan or describe in "NOTES" below. See back of form.

a

Date/time of first treatment:

Last date treated:

Hospitalized as inpatient? ☐ Yes ☐ No
If yes, name hospital:

Next appointment date:

Est. length of further treatment:

Current diagnosis per ICD-9-CM code(s):

b

Has the injury or illness caused permanent impairment?
☐ Yes ☐ No ☐ Impairment expected ☐ Unknown

Medically stationary? ☐ Yes (date): ☐ No (anticipated date):

(Attach findings of impairment, if any.)

Work ability status:
☐ Regular work authorized start (date):
☐ Modified work authorized from (date): through (date, if known):
☐ No work authorized from (date): through (date, if known):

c

NOTES: Describe the following *or* check if chart notes are attached. ☐
(Chart notes should *specifically* describe items below.)

Symptoms:
Objective findings:
Type of treatment:
Lab/X-Ray results (if any):
Impairment findings (if any):
☐ Temporary ☐ Permanent
Physical limitations (if any):
Palliative care plan/justification:
If referred to another physician give name/address:
Surgery:
History (if closing report):
Remarks:

Health insurance provider name and phone: *(print or type)*

Physician's or nurse practitioner's name, degree, address, and phone: *(print, type, or use stamp)*

X

Physician's or nurse practitioner's signature *Date*

This form replaces and satisfies reporting requirements for Forms 827, 828, 829, 2215, and 2837. See Bulletin 292.

— Original and one copy to insurer
— Retain copy for your records
— Copy to worker immediately if initial claim, aggravation claim, or change of physician

827