



GOVERNMENT OF THE DISTRICT OF COLUMBIA
OFFICE OF RISK MANAGEMENT



Jed Ross
Chief Risk Officer

Public Sector Workers'
Compensation Program

FORM 3 - PHYSICIAN'S REPORT

For Help and Information, call (202) 442-HELP (4357)

*Completion and submission of this form is required to file a claim for benefits with the Public Sector Workers' Compensation Program (PSWCP). This form must be returned to the PSWCP within ten (10) calendar days of an examination of the injured employee. **This form must be completed by a physician.***

PATIENT INFORMATION

Name: _____

Telephone: _____

Address (with unit number, zip code):

E-mail: _____

Employing Agency: _____

Claim Number: _____

Last Four
of SSN: _____ DOB: _____

Occupation: _____

Date of Injury/Illness: _____

Injured at: _____

PHYSICIAN INFORMATION

Name: _____

Telephone: _____

Office Address (with unit number, zip code):

E-Mail: _____

Date of Examination: _____

Date Report Completed: _____

1. DESCRIBE HOW THE INCIDENT HAPPENED:

2. SUBJECTIVE COMPLAINTS:

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Claimant Name:

Claim No.:

3. HISTORY

3a. History of work related injury/illness reported by patient? ☐ Yes ☐ No If “yes,” explain.

3b. History of previous injuries or pre-existing conditions reported by patient? ☐ Yes ☐ No If “yes,” list conditions.

4. OBJECTIVE FINDINGS

4a. Physical Examination Summary:

Blood Pressure	☐ Normal	☐ Abnormal	Neck	☐ Normal	☐ Abnormal
Weight	☐ Normal	☐ Abnormal	Thoracic	☐ Normal	☐ Abnormal
Abdomen	☐ Normal	☐ Abnormal	Lumbosacral	☐ Normal	☐ Abnormal
Chest/Lungs	☐ Normal	☐ Abnormal	Heart	☐ Normal	☐ Abnormal
Ear, Eyes, Nose	☐ Normal	☐ Abnormal	Appearance/ Mental Status	☐ Normal	☐ Abnormal
Throat, Mouth	☐ Normal	☐ Abnormal			

X-Ray Taken? ☐ Yes ☐ No Findings Available? ☐ Yes ☐ No Attached? ☐ Yes ☐ No

X-Ray
Diagnosis: _____

Labs Completed? ☐ Yes ☐ No Results Available? ☐ Yes ☐ No Attached? ☐ Yes ☐ No

5. **WORK-RELATED DIAGNOSIS.** (If occupational illness, specify etiologic agent and duration of exposure.) Use additional paper, if necessary. Chemical or toxic compounds involved? ☐ Yes ☐ No

5a. Are your findings and diagnosis consistent with patient’s account of injury or onset of illness? ☐ Yes ☐ No If “no,” explain.

5b. Is there any other current condition that will impede or delay patient’s recovery? ☐ Yes ☐ No If “yes,” explain.

6. TREATMENT

6a. Describe treatment rendered.

6b. If further treatment is required, specify treatment plan/estimated duration.

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6c. Treatment plan (Specify Duration)

- ☐ Diagnostic tools/tests _____
- ☐ Procedures _____
- ☐ Therapy _____
- ☐ Medications _____
- ☐ Supplies _____
- ☐ Other _____

6e. Does the claimant need diagnostic tests or referrals?

☐ Yes ☐ No

Tests:

- ☐ CT Scan
- ☐ EMG/NCS
- ☐ MRI (specify): _____
- ☐ Labs (specify): _____
- ☐ X-rays (specify): _____
- ☐ Other (specify): _____

Referrals:

- ☐ Chiropractor
- ☐ Internist/Family Physician
- ☐ Occupational Therapist
- ☐ Physical Therapist
- ☐ Specialist in _____
- ☐ Other (specify): _____

All referrals, **MUST BE PRE-APPROVED**. Contact the Program to initiate pre-certification. Pre-certification is **NOT** required for physician office visits, and routine laboratory testing.

7. MAXIMUM MEDICAL IMPROVEMENT (MMI)

- ☐ Patient has reached MMI Date of MMI _____
- ☐ Patient is not at MMI, but is anticipated to be at MMI in/on _____
- ☐ MMI date is unknown at this time because _____

7a. Maintenance care after MMI ☐ Yes ☐ No If yes, specify care: _____

8. PERMANENT MEDICAL IMPAIRMENT (REQUIRED AT DISCHARGE OR RELEASE PRN)

- ☐ No permanent impairment ☐ Permanent Impairment (attach completed Form 3M and include supporting narrative)
- ☐ Anticipate permanent impairment ☐ Permanent Impairment not known at this time.

9. WORK STATUS

(i) Is patient able to work? ☐ Yes ☐ No

If yes, ☐ Without restrictions ☐ With restrictions until _____.

If no, Patient is unable to work from _____ to _____, and

- ☐ can return to Regular work on _____,
- ☐ can return to Modified work on _____, or
- ☐ ability to return to Regular or Modified work is dependent on next medical evaluation, which is scheduled for _____.

9a. Limitations/Restrictions: ☐ No Restrictions ☐ Temporary Restrictions ☐ Permanent Restrictions

- | | |
|--|---|
| ☐ Lifting (maximum weight in pounds) _____ lbs. | ☐ Walking _____ hours per day |
| ☐ Repetitive lifting _____ lbs. | ☐ Standing _____ hours per day |
| ☐ Carrying _____ lbs. | ☐ Sitting _____ hours per day |
| ☐ Pushing/Pulling _____ lbs. | ☐ Crawling _____ hours per day |

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Claimant Name: _____

Claim No.: _____

- | | | |
|--|--|--|
| ☐ Pinching/Gripping | ☐ Yes ☐ No | ☐ Kneeling _____ hours per day |
| ☐ Reaching away from body | ☐ Yes ☐ No | ☐ Squatting _____ hours per day |
| ☐ Overhead reaching | ☐ Yes ☐ No | ☐ Climbing _____ hours per day |
| ☐ Repetitive Motion Restriction | ☐ Yes ☐ No | ☐ Driving _____ hours per day |
| ☐ Other | | |

10. DOCTOR’S OPINION

10a. Is the claimant’s injury/illness causally related to his/her work activities? ☐ Yes ☐ No Explain basis for answer.

10b. For a recurrence claim, state the original work-place injury/illness and diagnosis. Provide the causal relationship between the present diagnosed condition(s) and the original work-place injury/illness.

Physician’s Signature: _____ License/Reg#: _____

This form can be sent to **ORM/PSWCP** by **either e-mail or fax.**

E-mail: wcsecure@dc.gov

Fax: (202) 535-1130