



GOVERNMENT OF THE DISTRICT OF COLUMBIA
OFFICE OF RISK MANAGEMENT



Jed Ross
Chief Risk Officer

Public Sector Workers'
Compensation Program

FORM 3RC – ANNUAL MEDICAL RECERTIFICATION

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

Completion and submission of this form is required to maintain compensation benefits with the Public Sector Workers' Compensation Program (PSWCP). This form must be returned to the PSWCP on or before the anniversary of the date you began receiving compensation benefits. **FAILURE TO RECERTIFY MAY RESULT IN TERMINATION OF BENEFITS.**

PATIENT INFORMATION (This section and name and claim number identification at the top of pages 2 and 3 are to be completed by Claimant)

Name: _____ Telephone: _____

Full Address: _____
Street address City State Zip

Claim Number: _____ Date of Injury: _____

SSN: _____ Occupation: _____

Date Last Worked: _____ Date of Birth: _____

PHYSICIAN INFORMATION (To be completed by Physician)

Name: _____ E-mail: _____

Office Address: _____
Street address City State Zip

Federal Tax ID No.: _____ Telephone: _____

Practice Name: _____ Fax: _____

Date of Examination: _____ Date Report Completed: _____

Date of First Exam/Treatment: _____ Date of Last Exam/Treatment: _____

1. **SUBJECTIVE COMPLAINTS.** Describe fully. Use additional paper, if necessary.

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Claimant Name: _____ **Claim No.:** _____

2. OBJECTIVE FINDINGS. *Use additional paper, if necessary.*

2a. 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					

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

2b. Is there any other current condition that will impede or delay patient's recovery? ☐ Yes ☐ No If "yes," explain.

3. CURRENT TREATMENT *Use additional paper, if necessary.*

3a. Describe treatment rendered.

3b. If further treatment is required, specify treatment plan/estimated duration.

3c. If hospitalized as inpatient, give hospital name and location.	Date Admitted	Estimated Stay
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3d. Treatment plan.

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

3e. 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, high-cost diagnostic procedures, x-rays, MRIs, physical therapy, occupational therapy, work hardening, surgery, and pain management **MUST BE PRE-APPROVED**. Contact the Program to initiate pre-certification. Pre-certification is **NOT** required for physician office visits, durable medical equipment and routine laboratory testing.

3f. Prognosis for recovery:

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3g. Assistive device prescribed for this claimant: ☐ Cane ☐ Crutches ☐ Orthotics ☐ Walker ☐ Wheelchair
☐ Other (specify): _____

4. 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 _____

4a. Maintenance care after MMI ☐ Yes ☐ No If yes, specify care: _____

5. PERMANENT MEDICAL IMPAIRMENT (REQUIRED AT DISCHARGE OR RELEASE PRN (PRO RE NATA))

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

6. WORK STATUS. 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 _____

6a. 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 |
| ☐ 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 _____ | |

7. DOCTOR'S OPINION

7a. Is the claimant's injury/illness causally related to his/her work activities? ☐ Yes ☐ No Explain. _____

7b. Are the patient's current complaints consistent with his/her history of the injury/illness? ☐ Yes ☐ No If "no," explain. _____

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

Return this form directly to **ORM by electronic mail, fax, or by regular mail** to the address below or to the patient. Claimants may return the form in person, weekdays between 8:30 a.m. and 5:00 p.m., electronic mail, fax or regular mail to the following address. You will need photo identification to enter the building:

Office of Risk Management

**One Judiciary Square, 441 Fourth Street, NW, Suite 800 South
 Washington, D.C. 20001**

Email: wcsecure@dc.gov

Fax: (202) 535-1130