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 Throat, Mouth	☐ Normal	☐ Abnormal		Appearance/ Mental Status	☐ Normal	☐ Abnormal			
X-Ray Taken?	☐ Yes	☐ No	Findings Available?	☐ Yes	☐ No	Attached?	☐ Yes	☐ No	
Labs Completed?	☐ Yes	☐ No	Results Available?	☐ Yes	☐ No	Attached?	☐ Yes	☐ No	

X-Ray Diagnosis: _____

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

☐ 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