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) 727-8600

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.

PATIENT INFORMATION

Name: _____ **Telephone:** _____

Address (with unit number, zip code): **E-mail :** _____

_____ **Employing Agency:** _____

_____ **Claim Number:** _____

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:**

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

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.

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

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-authorization. Pre-authorization is **NOT** required for physician office visits.

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 _____

_____

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

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 **PSWCP by either e-mail or fax**.

E-mail: wcsecure@dc.gov
Fax: (202) 535-1130