GOVERNMENT OF THE DISTRICT OF COLUMBIA
OFFICE OF RISK MANAGEMENT

Jed Ross
Chief Risk Officer

Public Sector Workers' Compensation Program

FORM 3M – DOCTOR'S REPORT OF MMI / PERMANENT IMPAIRMENT

For Help and Information, call (202) 727-8600

Completion and submission of this form is required when making a claim for Permanent Disability Schedule Award.

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: **DOB:** **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:**

MAXIMUM MEDICAL IMPROVEMENT

Has the patient reached Maximum Medical Improvement? ☐ Yes ☐ No

If YES, provide the date patient reached MMI: _____/_____/_____

If NO, describe why the patient has not reached MMI and the proposed treatment plan (attach additional documentation, if necessary).

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

PERMANENT IMPAIRMENT / WORK STATUS

1. Is there permanent impairment? ☐ Yes ☐ No

If YES, complete below based on the patient's current condition, if you believe there is MMI and a permanent impairment or if directed by the ORM.

☐ **Loss, or loss of use, of body part:**
(Identify impairment rating according to the latest AMA Guidelines and attach separate sheet for additional body parts.)

Body Part: _____ Impairment %: _____
Body Part: _____ Impairment %: _____
Body Part: _____ Impairment %: _____

Describe findings and relevant diagnostic test results: _____

☐ **Facial Disfigurement:** (Describe Findings) _____

2. Patient's work status:

a. Is the patient working now? ☐ Yes, at pre-injury job ☐ Yes, at other employment ☐ No, Not Working

b. Could this patient perform his/her at-injury work activities without restrictions? ☐ Yes ☐ No

FUNCTIONAL CAPABILITIES / EXERTIONAL ABILITIES

1. Please describe patient's residual functional capacities for any work at this time (not limited to the at-injury job activities):

	Never	Occasionally	Frequently	Constantly
Lifting / Carrying	☐	☐ ____lbs.	☐ ____lbs.	☐ ____lbs.
Pulling / Pushing	☐	☐ ____lbs.	☐ ____lbs.	☐ ____lbs.
Sitting	☐	☐	☐	☐
Standing	☐	☐	☐	☐
Walking	☐	☐	☐	☐
Climbing	☐	☐	☐	☐
Kneeling	☐	☐	☐	☐
Bending / Stooping / Squatting	☐	☐	☐	☐
Simple grasping	☐	☐	☐	☐
Fine manipulation	☐	☐	☐	☐
Reaching overhead	☐	☐	☐	☐
Reaching at/or below shoulder level	☐	☐	☐	☐
Driving a vehicle	☐	☐	☐	☐
Operating machinery	☐	☐	☐	☐
Temp extremes / high humidity	☐	☐	☐	☐
Environmental Specify:	☐	☐	☐	☐
Psychiatric/neuro-behavioral (attach documentation describing functional limitations)	☐			

Patient's Residual Functional Capacities

Occasionally: can perform activity up to 1/3 of the time.

Frequently: can perform activity from 1/3 to 2/3 of the time.

Constantly: can perform activity more than 2/3 of the time.

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

2. Please check the applicable category for the patient's exertional ability:

- ☐ **Very Heavy Work** - Exerting in excess of 100 pounds of force occasionally, and/or in excess of 50 pounds of force frequently, and/or in excess of 20 pounds of force constantly to move objects. Physical demand requirements are in excess of those for Heavy Work. Heavy Work - Exerting 50 to 100 pounds of force occasionally, and/or 25 to 50 pounds of force frequently, and/or 10 to 20 pounds of force constantly to move objects. Physical demand requirements are in excess of those for Medium Work.
- ☐ **Medium Work** - Exerting 20 to 50 pounds of force occasionally, and/or 10 to 25 pounds of force frequently, and/or greater than negligible up to 10 pounds of force constantly to move objects. Physical demand requirements are in excess of those for Light Work.
- ☐ **Light Work** - Exerting up to 20 pounds of force occasionally, and/or up to 10 pounds of force frequently and/or negligible amount of force constantly to move objects. Physical demand requirements are in excess of those for Sedentary Work. Even though the weight lifted may only be a negligible amount, a job should be rated Light Work: (1) when it requires walking or standing to a significant degree; or (2) when it requires sitting most of the time but entails pushing and/or pulling of arm or leg controls; and/or (3) when the job requires working at a production rate pace entailing the constant pushing and/or pulling of materials even though the weight of those materials is negligible. NOTE: The constant stress of maintaining a production rate pace, especially in an industrial setting, can be and is physically demanding of a worker even though the amount of force exerted is negligible.
- ☐ **Sedentary Work** - Exerting up to 10 pounds of force occasionally and/or a negligible amount of force frequently to lift, carry, push, pull or otherwise move objects, including the human body. Sedentary work involves sitting most of the time, but may involve walking or standing for brief periods of time. Jobs are sedentary if walking and standing are required only occasionally and all other sedentary criteria are met.
- ☐ **Less than Sedentary Work** - Unable to meet the requirement of Sedentary Work

3. Are there other medical considerations which arise from this work related injury (including the use of pain medication such as narcotics)? ☐ Yes ☐ No If "YES," explain: _____

4. Could this patient perform his/her at-injury work activities with restrictions? ☐ Yes ☐ No
If "YES," explain: _____

5. Has the patient had an injury/illness since the date of injury which impacts residual functional capacity? ☐ Yes ☐ No If "YES," attach a detailed explanation.

6. Have you discussed the patient's return to work and/or limitations with any of the following: ☐ Patient ☐ Patient's Employer ☐ N/A

7. Would the patient benefit from vocational rehabilitation? If "YES," explain below.

PHYSICIAN CERTIFICATION UNDER PENALTY OF PERJURY

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

Return this form directly to **ORM by electronic mail, fax, or 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 c/o CorVel Corporation
One Judiciary Square, 441 Fourth Street, NW, Suite 800 South
Washington, D.C. 20001

Email: dcclaims@corvel.com
Fax: (866) 539-9712