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) 727-8600

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: **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:**

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 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

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

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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Claimant Name: ______________________ **Claim No.:** __________

3g. Assistive devise 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 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