

PHYSICIAN'S REPORT

Alaska Department of Labor
Alaska Workers' Compensation Board
P.O. Box 25512, Juneau, Alaska 99802-5512

- INITIAL** Employee: Sections 1 & 2/Physician: Sections 3 & 4
 PROGRESS Physician: Sections 1 & 4
 TREATMENT PLAN Employee: Sections 1 & 2/Physician: Sections 3 & 4

AWCB Case Number

SECTION 1	1. Employee's Name (Last, First, Middle Initial)		2. Insurer Claim Number		3. Injury Date														
	4. Address				5. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female		6. Social Security Number												
	City		State		Zip Code		Telephone		7. Birthdate										
	8. Employer				9. Insurer														
	10. Address				11. Address														
	City		State		Zip Code		Telephone		City		State		Zip Code		Telephone				
SECTION 2	12. Date Last Worked		13. Was Body Part Injured Before? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, when and describe:																
	14. Describe Injury and Tell How it Happened:																		
	15. Have You Seen any Other Doctor for this Injury? <input type="checkbox"/> No <input type="checkbox"/> Yes If yes, list name and address:								16. Hospitalized as Inpatient? <input type="checkbox"/> No <input type="checkbox"/> Yes Name of Hospital:										
SECTION 3	17. YOUR First Treatment Date:		18. Describe Complaints:																
	19. Fully Describe Findings on First Examination (Specify Right or Left):																		
	20. Diagnosis																		
	21. X-Rays? <input type="checkbox"/> No <input type="checkbox"/> Yes X-Ray Diagnosis:																		
	22. Is Condition Work Related? <input type="checkbox"/> No <input type="checkbox"/> Yes Explain: <input type="checkbox"/> Undetermined (Explain):																		
SECTION 4	23. Treatment Date(s) Since Last Report:				24. Next Treatment Date:		25. Estimate Length of Further Treatment Days Weeks Months												
	26. Medically Stable? <input type="checkbox"/> No <input type="checkbox"/> Yes		27. Date of Medical Stability		28. Injury May Permanently Preclude Return to Job at Time of Injury <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Undetermined			29. Will Injury Result in Permanent Impairment? <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> Undetermined											
	30. Impairment Rating:				31. Factors on Which Rating is Based:														
	32. Released for Work		<input type="checkbox"/> No Estimate Length of Disability: <input type="checkbox"/> 1-3 Days <input type="checkbox"/> 4-7 Days <input type="checkbox"/> 8-14 Days <input type="checkbox"/> 15-21 Days <input type="checkbox"/> 22-28 Days <input type="checkbox"/> More: _____ Weeks _____ Months																
			<input type="checkbox"/> Yes <input type="checkbox"/> Regular Work (date):		<input type="checkbox"/> Modified Work (date):		Give Limitations:												
	33. If the number of treatments will exceed Board's frequency standards, state the objectives, modalities, frequency of treatment, and reasons for frequency of treatments. Continue treatment plan on reverse if necessary. GIVE EMPLOYEE AND EMPLOYER/INSURER A COPY OF THIS REPORT.																		
	34. Describe Treatment (and/or Attach Chart Notes):																		
35. If Case Referred to Another Physician, State Name and Address:								36. IRS I.D. Number											
37. Physician's Name and Degree (Print or Type)				38. Physician's Signature				39. Report Date											
40. Address				City				State				Zip Code				41. Telephone			

