FORM ME-02

Workmen's Compensation Evaluation for Permanent Impairment

Instructions: This form must be completed only by a qualified examining doctor or physician authorized by the Workmen's Compensation Commission to conduct a permanent impairment evaluation. The examining doctor must furnish the completed form together with his official full evaluation report within 10-days after the examination to the employee and the employer's insurance carrier. It is the responsibility of the employee to facilitate all scheduling with the evaluating doctor for an examination and for such doctor to assist the employee on the requirement. No permanent impairment evaluation shall be conducted if the employee has not reached the clinical Maximum Medical Improvement (MMI) date.

1. **Name of Injured Employee** (First, M. Last):	2. **Sex:** ☐ Male | ☐ Female	3. **Date of Injury:**	4. **Date of Examination:**

5. **Name of Physician or Doctor Conducting Evaluation:**	6. **Physician's Specialization:**

7. Indicate doctor's role in performing this evaluation. Only such doctor can determine and assess both MMI and Permanent impairment disability:

- ☐ Primary Treating Physician (PTP)
- ☐ Designated by the Workmen's Compensation Commission
- ☐ Designated by an approved physician to conduct examination
- ☐ Selected by Insurance Carrier to evaluate MMI / PI

8. Physician's Mailing Address:

_____.

_____.

_____.

9. Physician's Contact Info:

Tel: ( ) _____.

Fax: ( ) _____.

Email: _____.

10. Location of Examination:

☐ LBJ – Fagaalu | ☐ Other (specify):

11. Indicate if the employee reached clinical Maximum Medical Improvement (MMI):

MMI literally does not mean the injury has completely healed but the patient has been given all possible medical treatments and options available. Therefore, based upon reasonable medical probability, the evaluating physician must determine the earliest date after which further material recovery from or lasting improvement to an injury can no longer reasonably anticipated.

☐ YES – I hereby certify that the employee has reached clinical MMI on the following date: _____ / _____ /_____

☐ NO – I hereby certify that the employee has not reached clinical MMI at this point

12. If the employee has reached the clinical MMI date, indicate if the employee has incurred any permanent impairment due to the injury.

The evaluating doctor is required to provide and enclosed a full report of his or her objective findings and examination on permanent disability together with this form. Permanent impairment disability injury must be assessed as either Permanent Partial Disability (PPD) or Permanent Total Disability (PTD) – not both. In pursuant to A.S.C.A. §32.0605, no injury is considered PTD unless it receives a rating of 100%. No impairment rating assessed and assigned for a particular bodily injury be converted, used, or assigned for another bodily injury. No impairment evaluation shall be conducted if the patient has not reached MMI date which is determined by the employee's primary treating physician or the designated doctor. A permanent impairment evaluation must be conducted using the *Guides to Evaluation of Permanent Impairment* published by the American Medical Association (AMA). Any percentage rating determined on such impairment must be specific on the injured part of the body – not as a whole person.

☐ NO – I hereby certify that the employee suffered no permanent impairment

☐ YES – I hereby certify that the employee suffered a permanent impairment for the following specific bodily injury:

I. Percentage Rating of Impairment Assessed: _____% to specific body injury: _____

- The evaluated impairment injury above is determined as: ☐ Permanent Partial ☐ Permanent Total

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II. A permanent impairment disability determined as a "whole person" or "whole body" is not accepted. If the examining doctor determines an impairment as a whole person, a converted rating should be determined for each specific body part impaired by the injury (particularly the lower and upper extremities – if affected).

Percentage Rating of Impairment Assessed: _____% of the whole body

- _____% specify body part: _____.
- _____% specify body part: _____.
- _____% specify body part: _____.

13. **Did the employee suffer any serious bodily disfigurement to the face, head, or body due to the injury?**

☐ No serious bodily disfigurement

☐ Yes (specify):

☐ Loss or amputation of limps | ☐ Visible deformity of limp or injured area | ☐ Visible scars due to injury | ☐ Surgical scars

☐ Others (explain):

14. **If you answered "Yes" in Item No. 13, briefly explain the bodily disfigurement (e.g.; type, physical dimensions, etc.):**

15. **Identify the AMA *Guides to Evaluation of Permanent Impairment* used to conduct your permanent impairment evaluation on the injury:**

☐ 3rd Edition (second printing) – February 1989

☐ 4th Edition (1st, 2nd, 3rd, or 4th printing) – including changes issued by AMA prior to May 16, 2000

☐ 6th Edition, second printing – April 2009

☐ Other Editions (specify): _____

16. **AUTHORIZATION:**

I hereby affirm and certify that the information provided within this form, including the full medical evaluation report as enclosed together with this form, is both complete, accurate, and conforms with all the requirements set by the Workmen's Compensation Commission. I also acknowledge my authority and medical certification or qualified expertise to properly assess permanent impairments using the required guidelines set by the American Medical Association (AMA) for Permanent Impairment, as well as my ability and capacity to determine MMI. I also understand that by making any misrepresentation on the claim or myself in the facilitation of this report is considered a crime, and any failure to provide this medical report as required before the Workmen's Compensation Commission shall be considered an obstruction of the employee's workmen's compensation proceedings which shall be punishable before the High Court of American Samoa as prescribed under A.S.C.A. §32.0550.

_____. _____.

SIGNATURE OF EVALUATING PHYSICIAN DATE

FORM DISTRIBUTION: Original – Employee | Copy – Carrier | Copy – Employer