

**Physician's First Medical Report of Injury (After First Treatment)**

Pursuant to A.S.C.A. §32.0619(c), the attending or primary treating physician is required to provide an initial report of the employee's work injury within 20-days following the first treatment or examination. To meet this reporting requirement, the treating physician must complete and submit this form to both the employer and the employer's workers compensation insurance carrier.

1. Patient's Name (First, M. Last):		2. Sex: <input type="checkbox"/> Male   <input type="checkbox"/> Female		3. Date of Birth:		4. Date of Injury:	
5. Date of first examination:		6. Date of first Treatment:		7. Does the patient have any pre-existing medical conditions, injury, and impairment? <input type="checkbox"/> Yes   <input type="checkbox"/> No			
8. Describe all pre-existing medical conditions, injury, or physical impairment found – if any:				9. Provide your objective findings of the injury:  (a) Physical Examination:   (b) X-Ray Results (or state <i>None</i> or <i>Pending</i> ):			
10. Provide your diagnosis of the injury:			11. Did injury require hospitalization? <input type="checkbox"/> No <input type="checkbox"/> Yes (specify):  Admission Date: _____  Discharge Date: _____		12. Does additional hospitalization on injury required? <input type="checkbox"/> No <input type="checkbox"/> Yes		
13. Does the Injury require surgery? <input type="checkbox"/> No <input type="checkbox"/> Yes		14. Any bodily disfigurement due to injury? <input type="checkbox"/> No <input type="checkbox"/> Yes (specify below): _____  <input type="checkbox"/> Amputation <input type="checkbox"/> Burned wounds <input type="checkbox"/> Deformity <input type="checkbox"/> Surgical wound <input type="checkbox"/> Abrasion Wound <input type="checkbox"/> Others		15. Objectively describe each disfigurement found – if any:			
16. Injury requires further special or specialized treatment off-island: <input type="checkbox"/> No <input type="checkbox"/> Yes							
17. Is the patient cleared to resume work? <input type="checkbox"/> No <input type="checkbox"/> Yes; (Date: _____   <input type="checkbox"/> Light Duties <i>or</i> <input type="checkbox"/> Full Duties				18. Do you anticipate a permanent impairment or defect on the injury – if any? Explain.			
19. Do you believe the diagnosis of condition found was caused or aggravated due to employment activity? Explain. (May attach separate sheet or evaluation if prefer)							
20. Name of Physician Making Report:							

X \_\_\_\_\_  
SIGNATURE OF PHYSICIAN

\_\_\_\_\_  
DATE OF REPORT