FORM ME-01

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

In 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:** ☐ Male | ☐ Female	3. **Date of Birth:**	4. **Date of Injury:**
5. **Date of first examination:**	6. **Date of first Treatment:**	7. **History of pre-existing medical conditions, injury, or physical impairment found?** ☐ Yes | ☐ 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 *None* or *Pending*):		
10. **Provide your diagnosis of the injury:**	11. **Did injury require hospitalization?** ☐ No | ☐ Yes (specify): Admission Date: _____ Discharge Date: _____	12. **Does additional hospitalization on injury required?** ☐ No ☐ Yes	
13. **Injury requires surgery:** ☐ No ☐ Yes – Date of surgery: _____	14. **Any bodily disfigurement due to injury?** ☐ No ☐ Yes (specify below): ☐ Amputation ☐ Burned wounds ☐ Deformity ☐ Surgical wound ☐ Open Wound ☐ Others	15. **Objectively describe each disfigurement found – if any:**	
16. **Injury requires further special or specialized treatment off-island:** ☐ **No** ☐ **Yes**			
17. **Is the patient cleared to resume work?** ☐ No ☐ Yes; (Date: _____) ☐ Light Duties *or* ☐ Full Duties	18. **If employee is not fit to return to work, specify date when patient may be reevaluated to resume work:**	19. **Do you anticipate any permanent impairment or defect on the injury – if any? Explain.**	
20. **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)			
21. **Name of Physician Making Report:**			

X _____.
SIGNATURE OF PHYSICIAN

_____.
DATE OF REPORT

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