State of Connecticut
Workers' Compensation Commission

Please TYPE or PRINT IN INK

Rev. 9-3-2010

42

WCC File # ____________________
Insurer # ____________________

Date filed in District

(for WCC use only)

Physician's Permanent Impairment Evaluation

The Form 42 should be mailed to ALL parties (employee, insurer, attorneys).

EMPLOYEE

Name ____________________

D.O.B. *(required)* ____________________

Address ____________________

City/Town ____________________ State ____________________

Zip Code ____________________ Tel.# ____________________

EMPLOYER

Name ____________________

INJURY

Date of Injury ____________________

City/Town of Injury ____________________

State ____________________ Zip Code ____________________

EVALUATION — IMPORTANT! Use a separate Form 42 for EACH body part!

Connecticut Statutes do NOT recognize whole person ratings [Section 31-308(b)].

Body Part ____________________

LIMB is .... ☐ LEFT .... ☐ RIGHT

HAND, ARM, or THUMB is .... ☐ MASTER .... ☐ MINOR

EYE is .... ☐ LEFT * .... ☐ RIGHT *

* Indicate: ☐ complete and permanent loss of sight
☐ reduction of sight to one-tenth (1/10) or less of normal vision

Which standards were utilized in your evaluation (AMA Edition # or Other Source):

____

Percentage of Permanent Loss (or Loss of Use) ____________________

Maximum Medical Improvement Exam Date ____________________

Does the patient have a work capacity? .... ☐ YES .... ☐ NO

If the patient DOES have a work capacity, please list any physical restriction(s):

____

____

____

____

CONNECTICUT-LICENSED PHYSICIAN — SIGNATURE

Name ____________________ Tel. # ____________________

Address ____________________

City/Town ____________________ State ____________________ Zip Code ____________________

Signature of Connecticut-Licensed Physician ____________________ Date ____________________

Print Name of Connecticut-Licensed Physician ____________________