State of Vermont
Department of Labor
Workers' Compensation Division

HCP1(Revised 7/2013)

State File #: _____
Ins. Co. File #: _____

Health Care Provider Report

Patient Information

Employee Name: _____ Date of Birth: _____

Address: _____

Phone Number: _____

Employer at time of injury: _____

Patient's subjective complaint regarding this injury: _____

Medical Information – Attach Additional Sheets if Necessary

Date of Injury: _____

Body Part and Nature of Injury: _____

Date of Examination: _____ ☐ Initial Visit ☐ Follow-up Visit

Diagnosis/Medical Condition: _____

This diagnosis/condition: ☐ is work related ☐ is not work related ☐ cause not yet determined

Provider's objective opinion regarding causal relationship: _____

Have diagnostic tests been performed: ☐ Yes ☐ No

Identify tests performed and results: _____

Treatment Plan: _____

Medications prescribed at this visit: _____

Other medications patient is taking as a result of this injury: _____

Work Capacity

☐ May return to work with NO RESTRICTIONS ☐ May not return to work
☐ May return to work with modified duty restrictions (see below)

Restrictions: _____

Health Care Provider Information

Name: _____

Address: _____

Phone Number: _____

Treatment Facility: _____

_____ _____
Health Care Provider's Signature Date

Narratives/Test Results Attached: ☐ Yes ☐ No