

Send Completed Form To: Zurich Insurance PO Box 968053 Schaumburg, IL 60196-8053 FAX: 215-861-6893

ATTENDING PHYSICIAN'S REPORT

Claimant Name	Claim Number
Claimant Address and Phone Number	Social Security Number –Last four digits
	Date of Injury
	Date(s) of Hospitalization
	Examination Date
	Next Appointment
Physician Name, Address and Phone Number	Injury Diagnosis
	Maximum Medical Improvement Achieved?
	Functional Capacity Evaluation Recommended?
	Independent Medical Evaluation Recommended?
May return to work without restrictions on	May return to work with restrictions as stated below
Temporarily and totally disabled from work	from through
from through	If the restrictions cannot be accommodated at work the
due to:	injured worker should remain off work. Please be specific; do not just state "light duty". The restrictions are:
Will this condition permanently prevent the employee from performing his or her duties? Yes No	
Objective Findings	
Subjective Findings	
Treatment Plan (medication prescribed, care needed, consultations, diagnostics, physical rehabilitation or surgery recommended)	
The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, we are asking that you not provide any genetic information when responding to this request for medical information. "Genetic Information" as defined by GINA includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.	
Physician Signature	Date

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This form is intended to provide the workers' compensation insurance carrier documentation for claims management, including but not limited to payment of wage loss benefits, coordination of return to work and authorization for recommended treatment.

All sections of this form are required fields.

The claimant's name and claim number are critical to direct the document to the correct claim file when it arrives at the workers' compensation insurance carrier's office.

Where a time frame is requested for a temporary total disability period, start and end dates must be specified. Responses such as "Unknown" or "Undetermined" will not result in an appropriate benefit update.

If enough space is not available on this form to describe restricted duty work restrictions please attach an amendment on the form of your choice.

Maximum medical improvement (MMI) means a condition that has become static or stabilized during a period of time sufficient to allow optimal recovery, and one that is unlikely to change in spite of further medical or surgical therapy.

A functional capacity evaluation (FCE) is performed by a medical professional qualified under Rule 20 measures and quantifies the physical abilities essential in performing a specific job and/or objectively defines functional abilities or limitations in the context of safe and productive work.

An independent medical evaluation (IME) is an examination by a qualified physician selected by the insurance carrier to render an opinion as to whether maximum medical improvement has occurred, degree of whole man impairment, if any, present and unmet treatment needs, if any.

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