



**STATE OF HAWAII**  
**DEPARTMENT OF LABOR AND INDUSTRIAL RELATIONS**  
**DISABILITY COMPENSATION DIVISION**  
 Princess Keelikolani Building, 830 Punchbowl Street, Room 209, Honolulu, Hawaii 96813  
**INSTRUCTION SHEET FOR FORM WC-2 PHYSICIAN'S REPORT**

**Instructions**

**Please completely fill out the WC-2 PHYSICIAN'S REPORT FORM.**

The **Delivery Information** section below lists various delivery options. Please select the most convenient method and submit the completed form accordingly.

**Please remember to sign and date the form before submitting it.**

**Delivery Information**

**Delivery by U.S. Mail, In-Person, or via Fax**

<b>Oahu</b>	<b>Kauai</b>	<b>Maui</b>
Princess Keelikolani Building 830 Punchbowl Street, Room 209 Honolulu, Hawaii 96813  Mailing Address: P.O. Box 3769 Honolulu, Hawaii 96812-3769  Phone: (808) 586-9161 Fax: (808) 586-9219	3060 Eiwa Street, Room 202 Lihue, Hawaii 96766  Phone: (808) 274-3351 Fax: (808) 274-3355	2264 Aupuni Street #2 Wailuku, Hawaii 96793  Phone: (808) 984-2072 Fax: (808) 984-2071
<b>Hawaii</b>	<b>West Hawaii</b>	
75 Aupuni Street, Room 108 Hilo, Hawaii 96720  Phone: (808) 974-6464 Fax: (808) 974-6460	Ashikawa Building 81-990 Halekii Street, Room 2087 Kealakekua, Hawaii 96750  If Mailing, Please Mail to This Address: P.O. Box 49, Kealakekua, Hawaii 96750  Phone: (808) 322-4808 Fax: (808) 322-4813	



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**FORM WC-2 PHYSICIAN'S REPORT**

**Note: PLEASE DO NOT WRITE IN SHADED BLOCKS**

1 First	2 First & Final	3 Final	4 Interim	5 Consulting	6 Rating
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Case Number
Date this report received
Mo. / Day / Yr.

Employer Name and Address		Carrier's Name and Address	
Patient's Name and Address		Your Name, Address and Telephone No.	
Patient's Social Security Number		Physician's ID	
Date of Injury/Illness Mo. / Day / Yr.	Date of First Treatment Mo. / Day / Yr.	If patient expired, give date Mo. / Day / Yr.	

- |  | Yes                      | No                       |
|--|--------------------------|--------------------------|
| 1. Are you the attending physician?                        | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Has the patient been burned?                            | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Is there a possibility of other disfigurement?          | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Do you think physical rehabilitation will be necessary? | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Do you think medical rehabilitation will be necessary?  | <input type="checkbox"/> | <input type="checkbox"/> |

State in patient's own words where and how the accident occurred:

Give accurate description and extent of injury: specify all parts of the body involved and state objective findings.

Is accident mentioned above the only cause of patient's condition?  Yes  No, state contributing causes.

# FORM WC-2 PHYSICIAN'S REPORT

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Who engaged your services?	
Is further treatment required? <input type="checkbox"/> No <input type="checkbox"/> Yes, period of time required?	
Were X-Rays taken? <input type="checkbox"/> No <input type="checkbox"/> Yes, by whom? Date(s)	
X-Ray Diagnosis:	
Was patient treated by anyone else? <input type="checkbox"/> No <input type="checkbox"/> Yes, by whom? Date(s)	
Was patient hospitalized? <input type="checkbox"/> No <input type="checkbox"/> Yes, date of admission:	Date of Discharge:
Name and Address of Hospital	
Describe subsequent treatment to be provided by you	
Did accident result in disability for work? <input type="checkbox"/> Yes <input type="checkbox"/> No, date disability began:	
Patient <input type="checkbox"/> was <input type="checkbox"/> will be able to resume <input type="checkbox"/> light work <input type="checkbox"/> regular work on:	
Patient stopped treatment without orders on	Patient discharged as cured on
Describe any permanent defect or disfigurement (include scars, discolorations, deformities, etc.) <input type="checkbox"/> None	
Final Diagnosis:	
Physician Signature	Date