PHYSICIAN'S AND CHIROPRACTOR'S PROGRESS REPORT CERTIFICATION OF DISABILITY

Claim Number:

Social Security Number:

Patient's Name:

Date of Injury:

Employer:

Name of MCO (if applicable)

Patient's Job Description/Occupation:

Previous Injuries/Diseases/Surgeries Contributing to the Condition:

Diagnosis:

Related to the Industrial Injury? Explain:

Objective Medical Findings:

" None - Discharged Stable " Yes " No Ratable " Yes " No

" Generally Improved " Condition Worsened " Condition Same

May Have Suffered a Permanent Disability " Yes " No

Treatment Plan:

" No Change in Therapy " PT/OT Prescribed " Medication May be Used While Working

" Case Management " PT/OT Discontinued

" Consultation

" Further Diagnostic Studies:

" Prescription(s)

" Released to **FULL DUTY**/No Restrictions on (Date): _____

" Certified **TOTALLY TEMPORARILY DISABLED** (Indicate Dates) **From:** _____ **To:** _____

" Released to **RESTRICTED**/Modified Duty on (Date): **From:** _____ **To:** _____

Restrictions Are: " Permanent " Temporary

" No Sitting " No Standing " No Pulling " Other: _____

" No Bending at Waist " No Stooping " No Lifting _____

" No Carrying " No Walking " Lifting Restricted to (lbs.): _____

" No Pushing " No Climbing " No Reaching Above Shoulders

Date of Next Visit:	Date of this Exam:	Physician/Chiropractor Name:	Physician/Chiropractor Signature: