SECOND INJURY FUND CERTIFICATION BY PHYSICIAN

Medical evaluation as described in RSA 281-A:54 and Administrative Rules Section Lab 506.04(2) must be filed within the prescribed time for filing the request for reimbursement in this claim.

Employee Name	Date of Subsequent Injury
Employer Name	Date of Subsequent Disability
Employer's Insurance Carrier	Adjusting Office Case Number

PLEASE NOTE CAREFULLY: This certification is to support an insurance company's claim that a worker, who has had a preexisting permanent impairment, has incurred a subsequent injury or illness which is work related. The insurer also contends that the combination of the previous impairment and the subsequent injury/illness results in a disability that is more severe than would have resulted from the subsequent injury alone. Your medical evaluation, provided below, will help to determine the validity of these contentions. Please be complete in providing your assessment of each medical condition and the combination of the two impairments. Thank you.

This is the certify that_____ a licensed practicing physician for_____ years, having an office in_____ City/Town examined the above named employee on _____ and finds as follows: Date

a) The employee's preexisting permanent impairment was diagnosed as:

b) The functional limitations caused by this preexisting impairment are as follows:

c) The employee's subsequent work related injury or illness was diagnosed as:

d) the employee's functional limitations following the subsequent injury are as follows:

e) Does the combination of the two impairments cause a greater disability than would have been caused by the subsequent injury alone?

☐ Yes ☐ No If yes, please describe how:

OR, in the case of death,

The death of the employee would not have occurred except for the employee's preexisting permanent physical or mental impairment. ☐ Yes ☐ No

Please specify the cause of death:

Date of Certification Physician's Signature