_____ Initial
_____ Interim
_____ Final

GEORGIA STATE BOARD OF WORKERS' COMPENSATION
MEDICAL REPORT

FAILURE TO SUBMIT THIS REPORT TO THE INSURER WILL JEOPARDIZE PAYMENT OF FEES

Employee Name (First) (Middle) (Last) | Employee's Phone Number | Social Security Number

Employee's Street Address | City | State | Zip | Date of Injury

Employer | Insurer

Address | Address

City | State | Zip | Phone | City | State | Zip | Phone

1. Date disability began	**2.Date of first treatment**	**3. Services authorized by** **____Employer** **____Dr._____** **____Other_____**
4. Patient's history		
5. Findings from examination		
6. Describe diagnosis		**ICD-9 Code**
7. Describe the treatment		
8. Prognosis		
9. Date of maximum recovery	**10. Doctors estimate of length of disability**	**11. Catastrophic Case Management recommended**
12. Date discharged as cured	**13. Date patient stopped treatment without an order**	**14. Date patient refused treatment**
15. a. Date patient able to return to work without restrictions_____ **b. Date patient able to return to work with restrictions _____** **c. List any restrictions _____**		**16. Hospital name and address if hospitalized**
17. Does employee have any permanent disability?_____Yes_____ No If any vision or hearing loss, see other side of form. **If yes, specify the part of body_____Percentage based upon AMA Guides_____%**		

Date of Service	CPT Code	Medical and Surgical Services and Drug (Itemize)	Units	Amount

18. Doctor's Name and Address	**19. Doctor's FEI/SSN**

By _____
(Signature of Doctor) **(Date)** **(Phone)**

FILE THREE (3) COPIES WITH INSURER OR SELF-INSURER (PLEASE TYPE)

Willfully making a false statement for the purpose of obtaining or denying benefits is a crime subject to penalties of up to $10,000.00 per violation (O.C.G.A. §34-9-18 and §34-9-19).

IF EMPLOYEE HAS ANY LOSS OF VISION OR HEARING, PLEASE GIVE THE AMOUNT OF DISABILITY

VISION READ ON UNCORRECTED VISUAL ACUITY HEARING Left ear _____500 _____1K _____2K

_____right eye _____left eye Right ear _____500 _____1K _____2K

By: _____

(Signature of Doctor) (Date)