Attending Physician's Report

Virginia Workers' Compensation Commission
1000 DMV Drive Richmond VA 23220
See instructions on the reverse of this form.

The boxes to the right are for the use of the insurer	Reserved	VWC file number
	Insurer code	Insurer location
	Insurer claim number	

Employee

1. Patient's name	2. Phone number	
3. Address	4. Date of birth	5. Sex ☐ Male ☐ Female
	6. Social security number	

Backgound Information

7. Name of employer	8. Address of employer	
9. Date of injury or illness		
10. Patient's account of how injury or exposure to occupational disease occurred		
11. Date of first visit	12. Date of discharge	13. Person authorizing treatment

Findings and Diagnosis

14. Findings upon examination, including results of x-rays, laboratory studies, etc. Please note any prior injuries and pre-existing conditions. Provide additional comments on the reverse side of this form.				
15. Diagnosis				16. Is diagnosed condition due to the occurrence described by the patient? ☐ Yes ☐ No ☐ Unknown
17. Nature of treatment				18. Dates of your treatment
19. Provide names and addresses of other health care providers to whom patient was referred				
20. Was there any fracture or amputation? ☐ Yes ☐ No ☐ Unknown	If yes	21. Please describe		
22. Was there disability for work? ☐ Yes ☐ No ☐ Unknown	If yes	23. Date disability began	24. Date able to return to light work	25. Date able to return to regular work
26. Will there be any permanent defect or disfigurement? ☐ Yes ☐ No ☐ Unknown	If yes	27. Please describe		28. Has patient reached maximum medical improvement? ☐ Yes ☐ No

Attending Physician

29. Name of attending physician	30. Address
31. Date of this report	

I certify that I personally examined and treated this patient

Signature ______________________________ M.D.

This report is required by the Virginia Workers' Compensation Act