Alaska Department of Labor
Alaska Workers' Compensation Board
P.O. Box 115512, Juneau, Alaska 99811-5512

PHYSICIAN'S REPORT

☐ **INITIAL** Employee: Sections 1 & 2/Physician: Sections 3 & 4
☐ **PROGRESS** Physician: Sections 1 & 4
☐ **TREATMENT PLAN** Employee: Sections 1 & 2/Physician: Sections 3 & 4

AWCB Case Number

SECTION 1

1. Employee's Name (Last, First, Middle Initial)
2. Insurer Claim Number
3. Injury Date
4. Address
5. Sex ☐ Male ☐ Female
6. Social Security Number
City State Zip Code Telephone
7. Birthdate
8. Employer
9. Insurer
10. Address
11. Address
City State Zip Code Telephone
City State Zip Code Telephone

SECTION 2

12. Date Last Worked
13. Was Body Part Injured Before? ☐ No ☐ Yes If yes, when and describe:
14. Describe Injury and Tell How it Happened:
15. Have You Seen any Other Doctor for this Injury? ☐ No ☐ Yes If yes, list name and address:
16. Hospitalized as Inpatient? ☐ No ☐ Yes Name of Hospital:

SECTION 3

17. YOUR First Treatment Date:
18. Describe Complaints:
19. Fully Describe Findings on First Examination (Specify Right or Left):
20. Diagnosis
21. X-Rays? ☐ No ☐ Yes X-Ray Diagnosis:
22. Is Condition Work Related? ☐ No ☐ Yes Explain:
☐ Undetermined (Explain):

SECTION 4

23. Treatment Date(s) Since Last Report:
24. Next Treatment Date:
25. Estimate Length of Further Treatment Days Weeks Months
26. Medically Stable? ☐ No ☐ Yes
27. Date of Medical Stability
28. Injury May Permanently PrecludeReturn toJob at Time of Injury ☐ No ☐ Yes ☐ Undetermined
29. Will Injury Result in Permanent Impairment? ☐ No ☐ Yes ☐ Undetermined
30. Impairment Rating:
31. Factors on Which Rating is Based:
32. Released for Work
☐ No Estimate Length of Disability: ☐ 1-3 Days ☐ 4-7 Days ☐ 8-14 Days ☐ 15-21 Days ☐ 22-28 Days ☐ More: _____ Weeks _____ Months
☐ Yes ☐ Regular Work (date): ☐ Modified Work (date): Give Limitations:
33. If the number of treatments will exceed Board's frequency standards, state the objectives, modalities, frequency of treatment, and reasons for frequency of treatments. Continue treatment plan on reverse if necessary. GIVE EMPLOYEE AND EMPLOYER/INSURER A COPY OF THIS REPORT.
34. Describe Treatment (and/or Attach Chart Notes):
35. If Case Referred to Another Physician, State Name and Address:
36. IRS I.D. Number
37. Physician's Name and Degree (Print or Type)
38. Physician's Signature
39. Report Date
40. Address City State Zip Code
41. Telephone