WORKER'S COMPENSATION INITIAL INJURY REPORT / PROVIDERS REPORT TO EMPLOYER
ENTIRA FAMILY CLINICS

Today's Date:_____
Employee Name_____ Date of Birth_____

Personal Health Insurance_____ ID #_____ Grp#_____
Subscriber Name_____ Date of Birth_____

Date of Injury (DOI) _____ Area of Body Injured_____ Claim #_____

Company Contact Person (Supervisor)_____Company Phone_____
Employer Name and Address_____
City State Zip
Occupation_____ Was Employer notified of this injury? ____ Yes _____ No
State how injury occurred_____
_____
List any prior significant related injury_____
Have you missed any work because of this injury? ____ Yes ____ No If so, what dates? _____
Did you receive any emergency treatment? _____ Yes _____ No, If so, Where?_____

Name and Address of Workers Comp Insurance_____
Name Street
_____
City State Zip

ASSESSMENT OF INJURY- Physician Comments:

Diagnosis:_____ Permanent disability likely ____Yes ____ No _____ Do not know
DID THIS INJURY PREVENT THE EMPLOYEE FROM WORKING? ____ Yes ____ No
If yes, the employee is / was:

A. Totally unable to work from _____through_____.
B. Able to return to work with restrictions (see below Physical Capabilities) from _____ through_____.
C. Able to work without restrictions as of _____.
D. Hours per day may work_____.

Date of maximum medical improvement(MMI) _____ Return visit ____ Yes ____ No If yes, date of return visit_____
Patient referred to:_____

Physical Capabilities:

Injury Care Instruction:

Patient **CAN**	**Not at all**	**Occasionally 1-33%**	**Frequently 34-66%**	**Continuously 67-100%**
Lift /Carry up to 10lbs				
11-20 lbs				
21-50 lbs				
51-100 lbs				
Bend				
Twist / Turn				
Reach above shoulder level				
Reach below knee level				
Stand or walk				
Sit				

Use hands for repetitive action such as: Left [ ] Right [ ] Both [ ]

Simple grasping				
Firm grasping				
Fine manipulation				

Provider signature:_____Date:_____