



Claim number

Instructions for Injured Worker

- Please print or type and complete items 1 - 6 on this form.
- Give this form to your physician of record to complete items 7 - 13 on the reverse side of the form.
- When both your portion and the physician's portion are completed, send this form to the local BWC customer service office or self-insuring employer.
- If you have any questions on completing this form, please call the local BWC customer service office or self-insuring employer.

To Be Completed By Injured Worker

| | | | |
|---|--|---|-------------------------------|
| 1 | Name | Date of injury | Telephone number () |
| | Address | City | State Nine-digit ZIP code |
| 2 | Last date worked due to current period of work related disability: | | Return-to-work date: |
| 3 | Employer name (where injury/disease happened) | Is modified or light-duty work available with this employer? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Don't know | |
| 4 | Have you worked, in any capacity, (include full-time, part-time, self-employment or commission work) during the disability period shown above? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, provide employer name: | | |
| | Employer name (self, if self-employed) | Telephone number () | |
| | Address | City | State Nine-digit ZIP code |
| 5 | Have you received or filed for any of the following benefits since your injury? | | |
| | Unemployment compensation..... <input type="checkbox"/> Yes <input type="checkbox"/> No OBES claim number _____ | | |
| | Social Security retirement..... <input type="checkbox"/> Yes <input type="checkbox"/> No Social Security claim number _____ | | |
| | Sick leave <input type="checkbox"/> Yes <input type="checkbox"/> No From _____ to _____ | | |
| | Public assistance..... <input type="checkbox"/> Yes <input type="checkbox"/> No Human services case number _____ | | |
| | Wage continuation..... <input type="checkbox"/> Yes <input type="checkbox"/> No From _____ to _____ | | |
| | Have you applied for or are you receiving other benefits from any other source regarding this injury? <input type="checkbox"/> Yes <input type="checkbox"/> No | | |
| | If yes, give Agency/Company name _____ | | Claim number _____ |

Injured Worker Signature

| | | | |
|---|---|---------|------|
| 6 | I understand I am not permitted to work while receiving temporary total compensation. I have answered the foregoing questions truthfully and completely. I am aware that any person who knowingly makes a false statement, misrepresentation, concealment of fact or any other act of fraud to obtain compensation as provided by BWC or who knowingly accepts compensation to which that person is not entitled is subject to felony criminal prosecution and may, under appropriate criminal provisions, be punished by a fine, imprisonment or both. | | |
| | Signature (if unable to sign, mark before two witnesses) | | Date |
| | Witness | Witness | |

Failure to complete this form, as instructed, may delay or suspend compensation payment.

Instructions to physician

- Please complete items 7 - 13, injured worker name and claim number on this form.
- You may attach additional medical documentation such as diagnostic test results and current treatment plan to support this request.
- Failure to provide complete information may delay or suspend compensation payments to the injured worker.

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|---------------------|
| Injured worker name |
| Claim number |

To Be Completed By Physician of Record

| | | | | | | | | | | |
|---|---|---|---------------------------------------|------------------------------|---|---|--|--|---|--|
| <p>What was the injured worker's position of employment at the time of injury?</p> <hr/> | | | | | | | | | | |
| 7 | <p>Can the injured worker return to this position of employment? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Can the injured worker return to other employment, including light-duty work, alternative work, modified work or transitional work? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Please explain, listing any restrictions that may apply. Attach additional sheet if necessary.</p> | | | | | | | | | |
| 8 | <table border="1"> <tr> <td> <p>List diagnosis(es) for allowed conditions being treated, which prevent return to work.</p> <hr/> <hr/> </td> <td> <p>Date of last exam or treatment</p> </td> <td> <p>Next appointment date</p> </td> </tr> <tr> <td> <p>List diagnosis(es) for other allowed conditions being treated.</p> <hr/> <hr/> </td> <td colspan="2"> <p>Disability dates due to the work related injury/disease</p> <p>From: _____ To: _____</p> </td> </tr> <tr> <td></td> <td colspan="2"> <p>Return to work date</p> <p>____ / ____ / ____ <input type="checkbox"/> Actual <input type="checkbox"/> Estimated <input type="checkbox"/> Released</p> </td> </tr> </table> | <p>List diagnosis(es) for allowed conditions being treated, which prevent return to work.</p> <hr/> <hr/> | <p>Date of last exam or treatment</p> | <p>Next appointment date</p> | <p>List diagnosis(es) for other allowed conditions being treated.</p> <hr/> <hr/> | <p>Disability dates due to the work related injury/disease</p> <p>From: _____ To: _____</p> | | | <p>Return to work date</p> <p>____ / ____ / ____ <input type="checkbox"/> Actual <input type="checkbox"/> Estimated <input type="checkbox"/> Released</p> | |
| <p>List diagnosis(es) for allowed conditions being treated, which prevent return to work.</p> <hr/> <hr/> | <p>Date of last exam or treatment</p> | <p>Next appointment date</p> | | | | | | | | |
| <p>List diagnosis(es) for other allowed conditions being treated.</p> <hr/> <hr/> | <p>Disability dates due to the work related injury/disease</p> <p>From: _____ To: _____</p> | | | | | | | | | |
| | <p>Return to work date</p> <p>____ / ____ / ____ <input type="checkbox"/> Actual <input type="checkbox"/> Estimated <input type="checkbox"/> Released</p> | | | | | | | | | |
| 10 | <p>The following clinical findings are the basis for my recommendations:</p> <p>Objective _____ Subjective _____</p> | | | | | | | | | |
| 11 | <p>Has the work-related injury(s) or disease reached a treatment plateau at which no fundamental functional or physiological change can be expected despite continuing medical or rehabilitative intervention (maximum medical improvement)? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes give date _____</p> <p>If no, indicate any barriers preventing normal recovery, or maximum medical improvement. Attach an additional sheet if necessary.</p> | | | | | | | | | |
| 12 | <p>Is the injured worker a candidate for vocational rehabilitation services focusing on return to work? <input type="checkbox"/> Yes <input type="checkbox"/> No Please explain:</p> | | | | | | | | | |

Physician of Record Signature - Mandatory

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|--|--------------------------|------|-------|--|------------------|
| <p>I certify that the above information is correct to the best of my knowledge. I am aware that any person who knowingly makes a false statement, misrepresentation, concealment of fact or any other act of fraud to obtain payment as provided by BWC or who knowingly accepts payment to which that person is not entitled is subject to felony criminal prosecution and may, under appropriate criminal provisions, be punished by a fine or imprisonment or both.</p> | | | | | |
| 13 | Physician of record name | | | BWC provider number - mandatory | |
| | Address | City | State | Nine-digit ZIP code | Telephone number |
| | | | | | () |
| Physician of record signature | | | | | Date |