Only Section 1 and Section 2 are required.

PHYSICIAN'S REPORT

ALASKA DEPARTMENT OF LABOR & WORKFORCE DEVELOPMENT
Alaska Workers' Compensation Board
P.O. Box 115512, Juneau AK 99811-5512

◯ **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. Date of Injury
4. Address				5. Sex ◯ Male ◯ Female	6. Social Security Number
City	State	Zip Code	Telephone		7. Date of Birth
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 Preclude Return to Job 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 ◯ Yes Estimate Length of Disability ◯ 1-3 Days ◯ 4-7 Days ◯ 8-14 Days ◯ 15-21 Days ◯ 22-28 Days ◯ More _____ Weeks _____ Months
◯ 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 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

SEE INSTRUCTIONS ON BACK

INSTRUCTIONS TO PHYSICIANS:

1. Clearly mark on reverse whether you are making an Initial, Treatment Plan, or Progress Report.
2. When making an Initial Report or Treatment Plan Report, ask employee to complete Sections 1 and 2. You should complete Sections 3 and 4.
3. When making a Progress Report, complete Items 1, 3, 6, 7, 8 and 9 of Section 1 (you may complete additional items for your own convenience) and Section 4.
4. A Treatment Plan IS REQUIRED ONLY if you treat the injured worker MORE OFTEN than provided in the following chart:

1st MONTH	2nd & 3rd MONTHS	4th & 5th MONTHS	6th THRU 12th MONTH
3 treatments per week	2 treatments per week	1 treatment per week	1 treatment per month

5. Within 14 days after each treatment, send the ORIGINAL report to the Employer. If you treat the employee more frequently than once every 14 days, you may report all treatments during a 14-day period on one form.
6. Send your billing only to the employer/insurer; the Board does not pay medical expenses.
7. If you need more space than that provided on the front of the form, use the space below.
8. You may make copies of this form.
9. Late or incomplete reporting may delay the employee's compensation payments. The employer/insurer may not be required to pay your treatment if reports are not submitted timely.

INSTRUCTIONS TO EMPLOYEE:

1. Complete Sections 1 and 2 of the Initial Report.
2. The report is NOT a substitute for your written notice of injury to your employer and the Alaska Workers' Compensation Board. If you have not already done so, immediately contact your employer and complete Items 1 through 17 of the Report of Occupational Injury or Illness (Form 07-6101).

42. Employee's Name (Last, First, Middle Initial)	43. Report Date
44. REMARKS (or Treatment Plan continued)	

Medical records in an employee's file maintained by the board are not public records subject to public inspection and copying under AS 09.25.