Medical Report Form
To be completed by treating physician

Patient Information

Patient's Name: _____

If patient is not employee, employee's name: _____

Relationship of patient to employee: _____

Diagnosis
Describe and locate site and extent of injury or illness

_____

_____

Is/was hospitalization required? _____ If so, date admitted: _____ Date discharged: _____

Maternity Section

Anticipated date of delivery: _____ Is delivery a planned C-section? _____

Disability Statement

Date disability began: _____ Patient is able to return to work on _____

Certification

Date form was completed: _____ Printed name of physician: _____

Physician's address: _____

Physician's signature (original required): _____