INSTRUCTIONS

1. Enter answers to all questions and submit to the Workers' Compensation Commission within 72 hours after first treatment.
2. DO NOT FAIL to forward to the Workers' Compensation Commission PROGRESS REPORTS and FINAL REPORT upon discharge of patient.

WORKERS' COMPENSATION COMMISSION

10 EAST BALTIMORE STREET, BALTIMORE, MD. 21202-1641

SURGEON'S REPORT

This is First Report ☐ **Progress Report** ☐ **Final Report** ☐

FOR WCC USE ONLY

WCC CLAIM #

EMPLOYER'S REPORT **Yes** ☐ **No** ☐

EVERY QUESTION MUST BE ANSWERED AND FORM SUBMITTED

1. Name of Injured Person: Last Name: First Name: MI Social Security. No. - - D.O.B / / Sex: M ☐ F ☐

2. Address: City: State: Zip: -

3. Employer Name: Address: City: State: Zip: -

4. Date of Accident or Onset of Disease: / / Hour: : A.M. ☐ P.M. ☐ 5. Date Disability Began: / /

6. Patient's Description of Accident or Cause of Disease:

7. Medical description of Injury or Disease:

8. Will Injury result in: (a) Permanent Defect? Yes ☐ No ☐ If so, what? (b) Disfigurement? Yes ☐ No ☐

9. Causes. other than injury, contributing to patients condition:

10. Is patient suffering from any disease of the heart, lunge, brain, kidneys, blood, vascular system or any other disabling condition not due to this accident?
Yes ☐ No ☐ Give Particulars:

11. Is there any history or evidence present of previous accident or disease?
Yes ☐ No ☐ Give Particulars:

12. Has normal recovery been delayed for any reason?
Yes ☐ No ☐ Give Particulars:

13. Date of first treatment: / / Who engaged your services? 14. Describe treatment given by you:

15. Were X-Rays taken? Yes ☐ No ☐ By? Name: Address: City: State: Zip: - Date: / /

16. X-Ray Diagnosis:

17. Was patient treated by anyone else? Yes ☐ No ☐ By? Name: Address: City: State: Zip: - Date: / /

18. Was patient hospitalized? Yes ☐ No ☐ Name and Address of Hospital Name: Address: City: State: Zip: - Date of Admission: / / Date of Discharge: / /

19. Is further treatment needed? Yes ☐ No ☐ For how long?

20. Patient was ☐ will be ☐ able to resume regular work on: / /
Patient was ☐ will be ☐ able to resume light work on: / /

21. If death ensued give date: / / 22. Remarks: (Give any information of value not included above)

23. **Physician:** I am a qualified specialist in: I am a duly licensed Physician in the State of:

I was graduated from Medical School (Name): Year: License No.

Last Name: First Name: MI Phone: ( ) -

Address: City: State: Zip: -

Email: **Date of this Report:**