THE GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF EMPLOYMENT SERVICES
OFFICE OF WORKERS' COMPENSATION
4058 Minnesota, Avenue, N.E.
WASHINGTON, DC 20019
(202) 671-1000

Date of This Report: _____

Employee Social Security No. _____

Employer Identification No. _____

Insurer No. _____

MEDICAL REPORT

IMPORTANT – THIS REPORT SHALL BE FILED IMMEDIATELY. FAILURE TO COMPLY WITHIN TWENTY (20) DAYS CAN RESULT IN UNNECESSARY DELAY IN PAYMENT OF BENEFITS TO THE INJURED WORKER AND PAYMENT FOR SERVICES RENDERED. (sec. 8, d)

EMPLOYEE _____
(Name) (Age) (Sex) (Soc. Sec. No.)

EMPLOYER _____
(Name) (Address) (Identification No.)

CARRIER _____
(Name) (Address) (Policy No.)

PHYSICIAN _____
(Name) (Address) (Specialty) (Tel. No.)

FOR USE OF PHYSICIAN

Accident	1. Date of accident: _____ 2. Time :_____AM/PM 3. Date disability began: _____ 4. State where and how the accident occurred as described by patient: _____
Injury	5. Give diagnosis of injury or disease: _____ 6. Will the injury result in a permanent defect? _____7. If so, what? _____ 8. Has the patient any physical impairment due to previous injury or disease? _____ If so, what? _____ 9. State physical limitations, if any: _____ 10. In your opinion is the injury and disability as a result of the accident described in (4) above? ☐ Yes ☐ No
Treatment	11. Date of your first treatment: _____ 12. Describe: _____ 13. Who engaged your services? _____ 14. Were X-Rays taken? ☐ Yes ☐ No 15. When? _____ 16. Where? _____ 17. X-Ray diagnosis: _____ 18. Did anyone else treat the patient? ☐ Yes ☐ No 19. If so, who? _____ 20. When? _____ 21. Hospital, if any? _____ 22. Admission Date: _____ 23. Discharge Date:_____ 24. If further treatment needed? ☐ Yes ☐ No 25. How long? _____
Disability	26. Will the patient ever be able to resume their regular occupation? ☐ Yes ☐ No 27. Expected length of disability? ☐ 2 weeks ☐ 1 month ☐ 3 months ☐ 6 months or longer ☐ Unknown 28. Patient was or will be able to resume regular work on: _____ 30. Date of death, if any? _____

_____
Physician's IRS Number

_____
Physician's Signature

_____
Date