PHYSICIAN'S AND CHIROPRACTOR'S PROGRESS REPORT CERTIFICATION OF DISABILITY

Claim Number:	
Social Security Number:	
Patient's Name:	Date of Injury:
Employer:	Name of MCO (if applicable)
Patient's Job Description/Occupation:	
Previous Injuries/Diseases/Surgeries Contributing to the Condition:	
Diagnosis:	
Related to the Industrial Injury? Explain:	
Objective Medical Findings:	

❑ None - Discharged Stable ❑ Yes ❑ No Ratable ❑ Yes ❑ No

❑ Generally Improved ❑ Condition Worsened ❑ Condition Same

May Have Suffered a Permanent Disability ❑ Yes ❑ No

Treatment Plan:

❑ No Change in Therapy ❑ PT/OT Prescribed ❑ Medication May be Used While Working

❑ Case Management ❑ PT/OT Discontinued

❑ Consultation

❑ Further Diagnostic Studies:

❑ Prescription(s)

❑ Released to **FULL DUTY**/No Restrictions on (Date): _____

❑ Certified **TOTALLY TEMPORARILY DISABLED** (Indicate Dates) **From:** _____ **To:** _____

❑ Released to **RESTRICTED**/Modified Duty on (Date): **From:** _____ **To:** _____

Restrictions Are: ❑ Permanent ❑ Temporary

❑ No Sitting	❑ No Standing	❑ No Pulling	❑ Other: _____
❑ No Bending at Waist	❑ No Stooping	❑ No Lifting	_____
❑ No Carrying	❑ No Walking	❑ Lifting Restricted to (lbs.): _____	
❑ No Pushing	❑ No Climbing	❑ No Reaching Above Shoulders	

Date of Next Visit:	Date of this Exam:	Physician/Chiropractor Name:	Physician/Chiropractor Signature: