

**PHYSICIAN'S AND CHIROPRACTIC PHYSICIAN'S
PROGRESS REPORT
CERTIFICATION OF DISABILITY**

Claim Number:
Social Security Number:
Date of Injury:

Patient's Name:

Employer:	Name of MCO (if applicable)
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Patient's Job Description/Occupation:

Previous Injuries/Diseases/Surgeries Contributing to the Condition:

Diagnosis:

Related to the Industrial Injury? Explain:
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Objective Medical Findings:

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<input type="checkbox"/> None - Discharged Stable <input type="checkbox"/> Yes <input type="checkbox"/> No Ratable <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Generally Improved <input type="checkbox"/> Condition Worsened <input type="checkbox"/> Condition Same May Have Suffered a Permanent Disability <input type="checkbox"/> Yes <input type="checkbox"/> No

Treatment Plan:

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<input type="checkbox"/> No Change in Therapy <input type="checkbox"/> PT/OT Prescribed <input type="checkbox"/> Medication May be Used While Working <input type="checkbox"/> Case Management <input type="checkbox"/> PT/OT Discontinued

<input type="checkbox"/> Consultation <input type="checkbox"/> Further Diagnostic Studies: <input type="checkbox"/> Prescription(s)	<table border="1"> <tr><td> </td></tr> <tr><td> </td></tr> <tr><td> </td></tr> <tr><td> </td></tr> <tr><td> </td></tr> <tr><td> </td></tr> </table>						

<input type="checkbox"/> Released to FULL DUTY /No Restrictions on (Date): _____ <input type="checkbox"/> Certified TOTALLY TEMPORARILY DISABLED (Indicate Dates) From: _____ To: _____ <input type="checkbox"/> Released to RESTRICTED /Modified Duty on (Date): From: _____ To: _____ <p align="center">Restrictions Are: <input type="checkbox"/> Permanent <input type="checkbox"/> Temporary</p>
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<input type="checkbox"/> No Sitting <input type="checkbox"/> No Standing <input type="checkbox"/> No Pulling <input type="checkbox"/> Other: _____ <input type="checkbox"/> No Bending at Waist <input type="checkbox"/> No Stooping <input type="checkbox"/> No Lifting _____ <input type="checkbox"/> No Carrying <input type="checkbox"/> No Walking <input type="checkbox"/> Lifting Restricted to (lbs.): _____ <input type="checkbox"/> No Pushing <input type="checkbox"/> No Climbing <input type="checkbox"/> No Reaching Above Shoulders
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Date of Next Visit:	Date of this Exam:	Physician/Chiropractic Physician Name:	Physician/Chiropractic Physician Signature:
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