# REPORT OF ATTENDING PHYSICIAN

State Form 2118 (R2/9-91)

*PRIVACY NOTICE * Your Social Security number is being requested by this state agency in order to pursue its statutory responsibilities. Disclosure is voluntary and you will not be penalized for refusal.*

WORKER'S COMPENSATION BOARD
INDIANA GOVERNMENT CENTER SOUTH
402 W WASHINGTON ST RM W196
INDIANAPOLIS IN 46204

***INSTRUCTIONS:*** *This form may be used by the attending physician or independent medical examiner.*

## PATIENT INFORMATION

| * Social Security number | Name of injured employee | Age | Sex ☐ Male ☐ Female |
|---|---|---|---|
| Address *(number and street, city, state, ZIP code)* | | | |
| Name of employer | | Date of this report | |
| Address *(number and street, city, state, ZIP code)* | | | |

## ACCIDENT INFORMATION

| Date of injury | Time of injury / illness / exposure ☐ _____ A. M. ☐ _____ PM | Date of disability |
|---|---|---|
| Describe accident / exposure | | |

## INJURY INFORMATION

State objective findings of injury / illness / exposure

Is this the only cause of patient's condition? *(If No, state contributing causes)*

☐ Yes ☐ No

Has normal recovery been delayed for any reason? *(If Yes, please explain)*

☐ Yes ☐ No

## ATTENDING PHYSICIAN TREATMENT

| Date of your first treatment | Who engaged your services? | | |
|---|---|---|---|
| Describe treatment given by you | | | |
| Was patient treated by anyone else? *(If Yes, by whom, give name)* ☐ Yes ☐ No | | | Date treated |
| Was patient hospitalized? ☐ Yes ☐ No | Name of hospital | Date of admission | Date of discharge |
| Is further treatment needed? *(If Yes, please explain)* ☐ Yes ☐ No | | | |

**(This portion may be used by attending physician and/or independent medical examiner)**

*(Check one)*

Patient ☐ was ☐ will be able to resume regular work on *(date)* _____.

*(Check one)*

Patient ☐ was ☐ will be able to resume light duty work on *(date)* _____. *(Please explain any restrictions below)*

If there is permanent impairment as a result of this injury / illness / exposure, please give body part affected, degree of impairment and other pertinent information. *(If there is an amputation to any of the fingers or thumb please indicate the point of amutation on the diagram below.)*

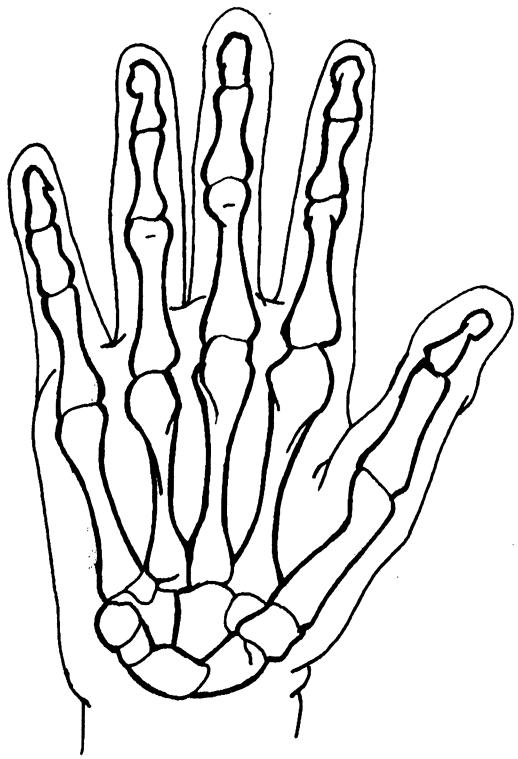
Remaks: *(Use this section for an independent medical examination report or give any information of value not included above i.e. history, prognosis, or work restrictions of the patient)*

Address of physician *(number and street, city, state, ZIP code)*

Date

Telephone number

( )



Is this report submitted as an independent medical examination? ☐ Yes ☐ No

Is further treatment necessary? *(If necessary, please explain response in the remarks section above. Supplemental reports may be submitted with this form.)* ☐ Yes ☐ No

Is course of medical treatment reasonable? *(If necessary, please explain in remarks, section above.)* ☐ Yes ☐ No

Signature of physician

Date signed