STATE OF HAWAII
DEPARTMENT OF LABOR AND INDUSTRIAL RELATIONS
DISABILITY COMPENSATION DIVISION
Princess Keelikolani Building, 830 Punchbowl Street, Room 209, Honolulu, Hawaii 96813

INSTRUCTION SHEET FOR FORM WC-2 PHYSICIAN'S REPORT

Instructions

Please completely fill out the WC-2 PHYSICIAN'S REPORT FORM.

The **Delivery Information** section below lists various delivery options. Please select the most convenient method and submit the completed form accordingly.

Please remember to sign and date the form before submitting it.

Delivery Information

Delivery by U.S. Mail, In-Person, or via Fax

Oahu	Kauai	Maui
Princess Keelikolani Building 830 Punchbowl Street, Room 209 Honolulu, Hawaii 96813 Mailing Address: P.O. Box 3769 Honolulu, Hawaii 96812-3769 Phone: (808) 586-9161 Fax: (808) 586-9219	3060 Eiwa Street, Room 202 Lihue, Hawaii 96766 Phone: (808) 274-3351 Fax: (808) 274-3355	2264 Aupuni Street #2 Wailuku, Hawaii 96793 Phone: (808) 984-2072 Fax: (808) 984-2071
Hawaii	**West Hawaii**	
75 Aupuni Street, Room 108 Hilo, Hawaii 96720 Phone: (808) 974-6464 Fax: (808) 974-6460	Ashikawa Building 81-990 Halekii Street, Room 2087 Kealakekua, Hawaii 96750 If Mailing, Please Mail to This Address: P.O. Box 49, Kealakelua, Hawaii 96750 Phone: (808) 322-4808 Fax: (808) 322-4813	

Visit our Website at www.hawaii.gov/labor for ALL interactive and downloadable forms.

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FORM WC-2 PHYSICIAN'S REPORT

Note: PLEASE DO NOT WRITE IN SHADED BLOCKS

1 First	2 First & Final	3 Final	4 Interim	5 Consulting	6 Rating
☐	☐	☐	☐	☐	☐

Case Number
Date this report received Mo. / Day / Yr.

Employer Name and Address	Carrier's Name and Address
Patient's Name and Address	**Your Name, Address and Telephone No.**
Patient's Social Security Number	**Physician's ID**

Date of Injury/Illness	Date of First Treatment	If patient expired, give date
Mo. / Day / Yr.	Mo. / Day / Yr.	Mo. / Day / Yr.

		Yes	No
1.	Are you the attending physician?	☐	☐
2.	Has the patient been burned?	☐	☐
3.	Is there a possibility of other disfigurement?	☐	☐
4.	Do you think physical rehabilitation will be necessary?	☐	☐
5.	Do you think medical rehabilitation will be necessary?	☐	☐

State in patient's own words where and how the accident occurred:

Give accurate description and extent of injury: specify all parts of the body involved and state objective findings.

Is accident mentioned above the only cause of patient's condition? ☐Yes ☐No, state contributing causes.

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Who engaged your services?
Is further treatment required? ☐No ☐Yes, period of time required?
Were X-Rays taken? ☐No ☐Yes, by whom? Date(s)
X-Ray Diagnosis:
Was patient treated by anyone else? ☐No ☐Yes, by whom? Date(s)
Was patient hospitalized? ☐No ☐Yes, date of admission: Date of Discharge:
Name and Address of Hospital
Describe subsequent treatment to be provided by you
Did accident result in disability for work? ☐Yes ☐No, date disability began:
Patient ☐was ☐will be able to resume ☐light work ☐regular work on:
Patient stopped treatment without orders on Patient discharged as cured on
Describe any permanent defect or disfigurement (include scars, discolorations, deformities, etc.) ☐None
Final Diagnosis:

Physician Signature	Date

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