Attending Physician's Supplementary Report

(Longshore and Harbor Workers' Compensation Act, as extended)

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U.S. Department of Labor
Employment Standards Administration
Office of Workers' Compensation Programs

INSTRUCTIONS: Use this form to make progress reports and to make a final report when the patient is discharged. Progress reports should be submitted about every thirty days, the original to the District Director (See Item 19. on page 2) and one copy to the insurance carrier or self-insured employer. Please answer all questions fully. If a question is not applicable, enter "NA". The exact point of amputation or other permanent partial impairment must be known to determine compensation the injured is entitled to receive. If preferred, physician may submit a narrative report covering all information requested on this form. Use "Remarks" on page 2 of form if more space is needed for any answer.

Print Reset

OMB No. 1215-0160

FOR OFFICE USE

OWCP No.

Carrier's No.

1. Type of report (Mark X one)

☐ Progress ☐ Final

2. Date of Injury (mm/dd/yyyy)

3. Name of injured employee

First Name | M.I. | Last Name

4. Employee's home address

line 1: | city:
line 2: | st: | zip:

5. Name of employer

6. Name of insurance carrier

7a. Have you filed a previous report giving history?

☐ Yes - Skip to item 8 ☐ No - Answer 7b and 7c

7b. State how injury occurred and give source of information. (If claim is for occupational disease, include occupational history and date of onset of related symptoms)

7c. Was employee previously under the care of another physician for this injury?

☐ No ☐ Yes - Give physician's name and address and reason for transfer

name:
line 1: | city:
line 2: | st: | zip:
reasons:

8. Is there any history or evidence of pre-existing injury, disease or physical impairment?

9a. Present condition (include diagnosis, subjective complaints, objective findings, and any changes of condition since last report.)

9b. If employee was hospitalized since last report, indicate and give name and address of hospital.

name:
line 1: | city:
line 2: | st: | zip:

This report is authorized by 33 U.S.C. 907(b). While you are not required to respond on this form, your cooperation is needed to insure that the injured worker's compensation case is properly processed by the U.S. Department of Labor. This form is used to request medical information which will be used to determine an injured worker's entitlement to compensation and medical benefits. Persons are not required to respond to this collection of information unless it displays a currently valid OMB control number.

10a. Describe treatment provided

10b. Date of first treatment (mm/dd/yyyy)

10c. Date of most recent treatment (mm/dd/yyyy)

10d. Has treatment been terminated? ☐ No ☐ Yes - Indicate reason

10e. Are you continuing treatment? ☐ Yes ☐ No

10f. If treatment is continuing estimate probable duration (mm/dd/yyyy)

11. Will the injury result in permanent restriction, total or partial loss of function of a part or member, or permanent disfigurement of the head, face, or neck, or some other part of the body which will handicap the employee in securing or maintaining employment?

☐ No ☐ Yes - Describe

12. Is employee working? ☐ Yes ☐ No

13. When do you estimate employee can - (mm/dd/yyyy)

a. Resume limited work of any kind Date

b. Resume regular work Date

14. If employee is unable to do his/her regular work, but can do limited work, specify work limitations due to this injury.

15. In your opinion, was the occurrence described above (or in the previous report which gave this information) the competent producing cause of the injury and disability?

☐ Yes ☐ No

16. Is rehabilitation treatment or services or evaluation recommended? ☐ Yes - Explain ☐ No - Explain

17. If rehabilitation treatment or services or evaluation is recommended, has referral been made? ☐ Yes - To whom ☐ No - Explain

18. Remarks

19. Send the original of your report to:

Office of the District Director
U.S. Department of Labor
Office of Workers' Compensation Programs

20. Name of attending physician (Type or print)

21. Signature of physician

22. Address

line 1: city:
line 2: st: zip:

23. Telephone No. (Area Code)

24. Date of report (mm/dd/yyyy)

Public Burden Statement

We estimate that it will take an average of 30 minutes to complete this collection of information, including time for reviewing Instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding these estimates or any other aspect of this collection of information, including suggestions for reducing this burden, send them to the U.S. Department of Labor, Division of Longshore and Harbor Workers' Compensation, Room C4315, 200 Constitution Avenue, N.W., Washington, D.C. 200210. DO NOT SEND THE COMPLETED FORM TO THIS OFFICE