Attending Physicians Report

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

MS 682-G

Record of Examination

1. Patient's name Last First Middle	2. Date of Injury mo. day yr	3. OWCP File Number	OMB No. 1215-0103 Expires: 10-31-94

4. What history of injury (including disease) did patient give you?

5. Is there any history or evidence of concurrent or pre-existing injury or disease or physical impairment? (If yes, please describe) ☐ Yes ☐ No	ICD-9 Code

6. What are your findings? (Include results of X-Rays, laboratory reports, etc.)

7. What is your diagnosis?	ICD-9 Code

8. Do you believe the condition found was caused or aggravated by an employment activity? (Please explain answer)
☐ Yes ☐ No

9. Did injury require hospitalization? If no, go to itme #13 ☐ Yes ☐ No	10. Date of admission mo. day yr.	11. Date of discharge mo. day yr.	12. Additional Hospitalization required If Yes, describe in "Remarks" (Item25) ☐ Yes ☐ No

13. What treatment did you provide?

14. Date of first examination mo. day yr.	15. Date(s) of treatment mo. day yr. mo. day yr. mo. day yr.	16. Date of discharge from treatment mo. day yr.

17. Period of total disability From mo. day yr. Thur mo. day yr.	18. Period of Partial Disability From mo. day yr. Thur mo. day yr.	19. Date employee able to resume Light work mo. day yr.

20. Date employee is able to resume regular work mo. day yr.	21. Has employee been advised that he/she can return to work? ☐ Yes ☐ No	22. If yes, on what date was he/she advised? mo. day yr.

23. If employee is able to resume only light work, indicate the extent of physical limitations and the type of work that could reasonably be performed with these limitations. (Continue in item #25 if necessary.)	24. Are any permanent effects expected as a result of this injury? If yes, describe in item #25. ☐ Yes ☐ No

25. Remarks

26. If you have referred the employee to another physician provide the following: Name	Specialty
Address	27. What was the reason for this referral?
City State Zip	☐ Consultation ☐ Treatment

Signature

28. I certify that the statements in response to the questions asked above are true, complete and correct to the best of my knowledge. Further, I understand that any false or misleading statement or any misrepresentation or concealment of material fact which is knowingly made may subject me to felony criminal prosecution.

Signature of Physician _____Date _____

29. Name of Physician	30. Tax ID Number

Address			31. Do you specialize? ☐ Yes ☐ No
City	State	Zip	32. If yes, indicate specialty

FORM CA-20, PHYSICIAN'S REPORT

Compensation for wage loss cannot be paid unless medical evidence has been submitted supporting disability for work during the period claimed. For claims based on traumatic injury and reported on Form CA-1, the employee should detach Form CA-20, complete items 1-3 on the front, and print the OWCP district office address on the reverse. The form should be promptly referred to the attending physician for early completion. If the claim is for occupational disease, filed on Form CA-2, a medical report as described in the instructions accompanying that form is required in most cases. The employee should bring these requirements to the physician's attention. It may be necessary for the physician to provide a narrative medical report in place of or in addition to Form CA-20 to adequately explain and support the relationship of the disability to the employment.

For payment of a schedule award, the claimant must have a permanent loss or loss of function of one of the members of the body or organs enumerated in the regulations (20 C.F.R. 10.304). The attending physician must affirm that maximum medical improvement of the condition has been reached and should describe the functional loss and the resulting impairment in accordance with the American Medical Association **Guides to the Evaluation o Permanent Impairment.**

PRIVACY ACT

In accordance with the Privacy Act of 1974 (Public Law No. 93-579, 5 U.S.C. 552a) and the Computer Matching and Privacy Protection Act of 1988 (Public Law No. 100-503), you are hereby notified that: (1) The Federal Employees' Compensation Act, as amended (5 U.S.C. 8101, et seq.) is administered by the Office of Workers' Compensation Programs of the U.S. Department of Labor. In accordance with this responsibility, the Office receives and maintains personal information on claimants and their immediate families. (2) The information will be used to determine eligibility for and the amount of benefits payable under the Act. (3) The information collected by this form and other information collected in relation to your compensation claim may be verified through computer matches. (4) The information may be given to Federal, State, and local agencies for law enforcement and for other lawful purposes in accordance with routine uses published by the Department of Labor in the Federal Register. (5) Failure to furnish all requested information may delay the process, or result in an unfavorable decision or a reduced level of benefits. (Disclosure of a social security number (SSN) is voluntary; the failure to disclose such number will not result in the denial of any right, benefit or privilege to which an individual may be entitled. Your SSN may be used to request information about you from

employers and others who know you, but only as allowed by law or Presidential directive. The information collected by using your SSN may be used for studies, statistics, and computer matching to benefit and payment files.)

THIS NOTICE SHOULD BE RETAINED FOR YOUR INFORMATION.

IMPORTANT: A MEDICAL REPORT IS REQUIRED BY THE OFFICE OF WORKERS' COMPENSATION PROGRAMS BEFORE PAYMENT OF COMPENSATION FOR LOSS OF WAGES OR PERMANENT DISABILITY CAN BE MADE TO THE EMPLOYEE.

IF YOU HAVE SUBMITTED A NARRATIVE MEDICAL REPORT OR A FORM CA-16 TO OWCP WITHIN THE PAST 10 DAYS, YOU NEED NOT SUBMIT THIS FORM CA-20.

OWCP REQUIRES THAT MEDICAL BILLS, OTHER THAN HOSPITAL BILLS, BE SUBMITTED ON THE AMERICAN MEDICAL ASSOCIATION HEALTH INSURANCE CLAIM FORM, HCFA 1500/OWCP-1500a.

INSTRUCTIONS TO PHYSICIAN FOR COMPLETING ATTENDING PHYSICIAN'S REPORT

1. COMPLETE THE ENTRIES 1-32 ON THE FORM; AND

2. IF DISABILITY HAS NOT TERMINATED, INDICATE IN ITEM 17; AND

3. SEND THE FORM AND YOUR BILL TO:

OFFICE OF WORKERS' COMPENSATION PROGRAMS

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,