ATTENDING PHYSICIAN'S REPORT OF ACCIDENT

(PLEASE PRINT OR TYPE)

CORRECTIONS AND CONDITIONAL RELEASE REGULATIONS

Inmate/claimant's name in full	FPS No.	Sex	Age of Injured Inmate
		◯ Male ◯ Female ◯ Another Gender	

Date of Injury	Who first rendered treatment? (name and title of individual)	Date you first examined inmate
(Year - Month - Day)		(Year - Month - Day)

What does inmate state caused the injury?

In your opinion, is there any misrepresentation or concealment in this case?

◯ Yes ◯ No If yes, please specify:

Dates examined by physician:

Injured inmate's initial complaints:

Physical examination revealed the following:

Describe any relevant previous disease, injury or deformity:

Results of any diagnostic tests:

Treatment rendered (include medication prescribed):

Treatment ongoing? If yes, please specify:

◯ Yes ◯ No

List any apparatus used or given (crutches, cane, cervical collar, brace, cast, sling):

If hospitalized, name and address of hospital:

Treatment rendered:

Period of confinement:

Diagnoses:

1.
2.
3.

Prognoses (check appropriate box and add comments)

☐ 1. Inmate has enjoyed a complete recovery and will experience no further difficulties.

Date inmate was able to resume regular work or activities (Year - Month - Day): _____

☐ 2. Inmate still incapacitated and symptoms will probably persist for a further _____ (days / months)

Probable date inmate will be able to resume regular work or activities (Year - Month - Day): _____

☐ 3. Inmate will remain with a permanent disability. Indicate the percentage of the disability of the whole man: _____

Additional Comments:

_____
Physician's Name (please print or type)

_____
Signature

_____
Date (Year - Month - Day)

Lab/Trav 229