

THE MERCHANT SEAMEN COMPENSATION ACT

Surgeon's First Report

The information you provide on this form is collected pursuant to the Merchant Seaman Compensation Act to establish validity of claims and determine monetary entitlement. Although the completion of this form is voluntary, all the information will be required before a decision can be made. If the information is not provided, a decision may be delayed or not made at all with respect to the individual qualifying for compensation benefits. The information will be stored in the Personal Information Bank Number LAB PPU 030. Under the Privacy Act , the individual to whom the information pertains may have rights to access.

(please type or print clearly)

Name of Injured Seaman:	Date of accident :
Address :	
Name of Employer :	
Address :	

1. Give date of examination upon which this report is based	
2. Describe fully the physical condition resulting from the accident	
3. Who rendered first treatment?	When did you first treat the case?
4. State your treatment (It is not sufficient to say "usual", "surgical", or "dressing applied", etc.) Indicate clearly the means taken to remedy the injury.	
5. At the time of examination, was seaman able to resume usual work? ☐ Yes ☐ No If yes, indicate date: If no, what kind of work could seaman do, if any:	
6. If still incapacitated, give probable date seaman will be able to resume work:	
7. Will there be any PERMANENT incapacity resulting from the accident? If yes, please specify: ☐ Yes ☐ No	
8. Had seaman, at the time of the accident, any pre-existing illness or physical handicap? (i.e. hernia, loss of sight, hearing, limbs, fingers, deformity of the spine etc.) or any other ailment not caused by the accident? ☐ Yes ☐ No If yes, please specify:	
9. Are you of the opinion that there might have been any false report, fraud, retinence, collusion or abuse in this case? ☐ Yes ☐ No If yes, please specify:	
10. Indicate the date of your next appointment with this person:	

If another Doctor or Hospital rendered services, please give name below

Name and address of Hospital, if any used			
Was operating room used?	☐ Yes	☐ No	
Was an X-ray examination required?	☐ Yes	☐ No	If Yes, by whom/address: _____
Was treatment by a Specialist required?	☐ Yes	☐ No	If Yes, give name/address: _____
Was assistant Physician required?	☐ Yes	☐ No	If Yes, give name/address: _____
Was patient anesthetized?	☐ Yes	☐ No	If Yes, give name/address: _____

This report calls for the Doctor's own opinion as to disability

_____ Name of Doctor (please print in block letters)	_____ Signature	_____ date
Address		