

**TENNESSEE DEPARTMENT OF LABOR AND WORKFORCE DEVELOPMENT
Division of Workers' Compensation
Nashville, Tennessee 37243-0661**

ATTENDING PHYSICIAN'S REPORT

It is a crime to knowingly provide false, incomplete or misleading information to any party to a workers' compensation transaction for the purpose of committing fraud. Penalties include imprisonment, fines and denial of insurance benefits.

THE PATIENT	1. Name of Injured Person:			
	SSN:	Age:	Sex:	
	2. Address:		City:	State: Zip:
	3. Employer Name:			
THE ACCIDENT	Address:		City:	State: Zip:
	4. Date of Accident:	Hour:	Date of Disability:	
	5. State in patient's own words where and how accident occurred:			
THE INJURY	6. Give accurate description of nature and extent of injury and state your objective findings:			
	7. Is accident referred to above only cause of patient's condition?			
	If not, state contributing causes:			
	8. Is patient suffering from any disease of the heart, lungs, brain, kidneys, blood, vascular system or any other disabling condition not due to this accident?			
	Give particulars:			
	9. Has patient any physical impairment due to previous accident or disease?			
	Give particulars:			
TREATMENT	10. Has normal recovery been delayed for any reason?			
	Give particulars:			
	11. Who engaged your services?			
	12. Date of your first treatment:			
	13. Describe treatment given by you:			
	14. Was patient treated by anyone else?		When?	
	15. Was patient hospitalized?		Name of hospital:	
	Address of hospital:			
	16. Date of admission to hospital:		Date of discharge:	
17. Is further treatment needed?		For how long?		
DIS-ABILITY	18. Will the injury result in:			
	(a) Permanent Defect?	If so, what?		
	(b) Facial or head disfigurement?			
	19. Date able to return to work:			
	20. Date able to return to work light duty:			
21. If death ensued, give date:				
	Remarks: (Give any information of value not listed above)			
	This report must be signed personally by physician.			
	Date of report:		Signed	
Address:		Telephone:		