

# Attending Physician's Report

Virginia Workers' Compensation Commission  
 1000 DMV Drive Richmond VA 23220  
 See instructions on the reverse of this form.

The boxes to the right are for the use of the Insurer	Reserved	VWC file number
	Insurer code	Insurer location
	Insurer claim number	

<b>Employee</b>		
1. Patient's name	2. Phone number	
3. Address	4. Date of birth	5. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
	6. Social security number	

<b>Background Information</b>		
7. Name of employer	8. Address of employer	
9. Date of injury or illness		
10. Patient's account of how injury or exposure to occupational disease occurred		
11. Date of first visit	12. Date of discharge	13. Person authorizing treatment.

<b>Findings and Diagnosis</b>		
14. Findings upon examination, including results of x-rays, laboratory studies, etc. Please note any prior injuries and pre-existing conditions. Provide additional comments on the reverse side of this form.		

15. Diagnosis	16. Is diagnosis condition due to the occurrence described by the patient? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
17. Nature of treatment	18. Dates of your treatment

19. Provide names and addresses of other health care Providers to whom patient was referred	
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20. Was there any fracture or amputation? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	if yes	21. Please describe		
Was there disability for work? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	if yes	23. Date disability began	24. Date able to return to light work	25. Date able to return to regular work
<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	if yes	27. Please describe		28. Has patient reached maximum medical improvement? <input type="checkbox"/> Yes <input type="checkbox"/> No

<b>Attending Physician</b>	
29. Name of attending physician	30. Address
31. Date of this report	

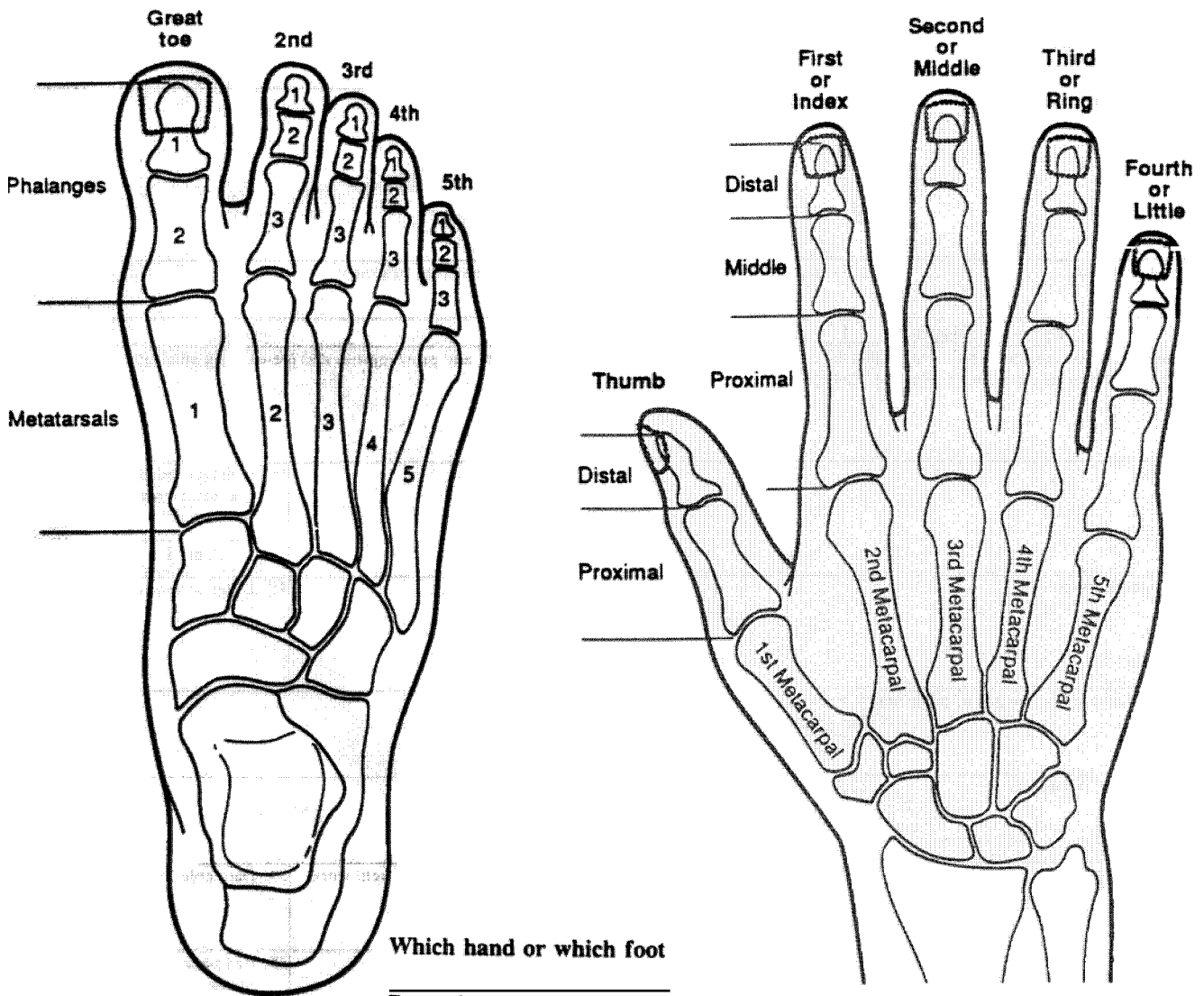
I certify that I personally examined and treated this patient  
 Signature \_\_\_\_\_ M D

# INSTRUCTIONS

## Attending Physician's Report VWC Form No. 6

Complete all parts of this form noting all injuries, no matter how minor. Type or print all information in black using this side of the form for any additional comments. Be sure to sign the form at the bottom.

Submit the report to the employer or to the employer's insurance carrier



Remarks