Attending Physician's Report

Return Completed Form To:

Workers' Compensation Division
P.O. Box 3151, Charleston, West Virginia 25332

FOR DIVISION USE ONLY

WC-219 Rev. 9-94

SECTION I: To be completed by the injured worker (FORM MAY BE RETURNED IF ALL QUESTIONS ARE NOT ANSWERED.)

1. Claim No. SS No. 2. Current Telephone No.
   Emp. Fisk No. DOI

Claimant's Name and Address **Employer's Name and Address**

3. ***Please mark any needed changes in your address as printed above.***
4. Have you performed any kind of work or have you received income for any work during the time you have been certified temporarily and totally disabled? ☐ Yes ☐ No
5. I hereby certify that the statements and answers set forth above are true and correct to the best of my knowledge and belief. I am aware that the law provides for severe penalties if I knowingly and with fraudulent intent withhold a material fact or make a false statement in order to obtain or increase a benefit that I am not entitled to.
   Claimant's Signature________________ Date ________

SECTION II: To be completed by the Attending Physician (PLEASE COMPLETE ALL QUESTIONS.) Attach Additional Pages If Necessary.

If claimant has reached maximum degree of medical improvement, please complete form WC-219a, NOTICE OF MAXIMUM MEDICAL IMPROVEMENT.

1. Date of this examination ___ | ___ | ___ (Month Day Year)
2. Date of next appointment ___ | ___ | ___ (Month Day Year)
3. A. Is this the first examination and/or treatment by you for this injury? ☐ Yes ☐ No If Yes, please advise as to how the claimant came under your care. ________

   B. Does claimant continue under your active care? ☐ Yes ☐ No If No, please explain. ________

   C. Has the claimant been referred to another physician for any of the following? (Check appropriate box(es) and explain basis for your referral.)
   ☐ Consultation ☐ Evaluation ☐ Treatment ________
4. Diagnosis (ICD9-CM) code and description
5. Please describe your treatment plan and list medications currently being prescribed, their dosages, and the refill limit.
6. Has normal or expected recovery been delayed due to complications, concurrent medical problems, pre-existing medical condition, subsequent trauma, etc? ☐ Yes ☐ No If Yes, please explain condition and how it has affected recovery.
7. Will claimant need rehabilitation services? ☐ Yes ☐ No If Yes, please specify.
8. Is claimant temporarily and totally disabled? ☐ Yes ☐ No If Yes, is disability due to compensable diagnosis or other causes? Please explain.
9. Please indicate the anticipated date claimant will be able to return to:
   Modified Work ___ | ___ | ___ Trial Return to Work ___ | ___ | ___ Full-time Work ___ | ___ | ___
10. If the claimant has **reached maximum medical improvement**, is there, or do you anticipate, any permanent impairment as a result of the compensable injury? ☐ Yes ☐ No If Yes, please complete form **WC-219a, Notice of Maximum Medical Improvement**.
11. Physician's Name, Address & Telephone No.

    FEIN
12. ________________
    Physician's Signature

    ____
    Date

INTERNET

Explanation of Terms

CLAIMANT:

The person to whom you are rendering medical services as a result of an occupational injury or disease.

COMPENSABLE INJURY OR DISEASE:

An injury or disease which occurred in the course of and as a result of one's employment. Injuries and diseases of other origins are not compensable under Workers' Compensation Law.

INJURY:

This term means personal injury, that is, injury to the person, whether physical or mental, incurred in the course of and resulting from one's covered employment.

MAXIMUM DEGREE OF MEDICAL IMPROVEMENT:

The claimant has either completely recovered from the effects of his or her compensable injury or disease or has recovered as much as is possible through medical treatment, either active or conservative.

PERMANENT IMPAIRMENT:

The claimant has reached maximum improvement and will likely have some residual impairment from the compensable injury or disease. It is not only possible, but expected, that the claimant will still be able to return to work with some degree of permanent impairment.

REHABILITATION SERVICES:

A variety of rehabilitation services is available to assist in returning injured workers to appropriate employment that is within their functional restrictions. Emphasis is placed upon an expedient return to employment in order to reduce loss of income for claimants and to reduce loss of production for employers.

RETURN TO WORK:

This means a return to the claimant's previous job or one requiring similar skills or activities. This does not mean that the claimant can work at a light duty job bearing little, if any, relationship to his/her usual occupation, unless the former employer will guarantee full-time employment on this basis. If you are in doubt about whether this is the case, the physician or the claimant should check with the employer.

TEMPORARY TOTAL DISABILITY (TTD):

The claimant is unable to return to substantial gainful employment requiring skills or activities comparable to those of his/her previous gainful employment during the healing or recovery period. In other words, the claimant is unable to return to his/her previous job or a similar form of work but may be able to do so after the course of medical treatment. TTD benefits are equal to 70% of a claimant's wages, not to exceed 100% of the average weekly wage in West Virginia.

NOTE: Workers' Compensation will only pay disability benefits for conditions directly related to the compensable injury or disease.