



Jurisdiction Claim Number (JCN)

Claim Administrator Number

### Injured Worker Information

Patient's Name		Date of Birth	Date of Injury/Occupational Disease	
Address		City	State	Zip Code
Name of Company/Employer		Address of Company/Employer		

Patient's account of how injury or exposure to occupational disease occurred

Date of first visit	Date of discharge	Person authorizing treatment
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### Findings and Diagnosis

Findings upon examination, including results of x-rays, laboratory studies, etc. Please note any prior injuries and pre-existing conditions.

Diagnosis	Is the diagnosed condition related to the on-the-job injury? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
Nature of treatment	Dates of treatment

Provide names and addresses of other health care providers to whom patient was referred.

Was there any fracture or amputation?  Yes  No If yes, please describe below.

Was there disability from work?  Yes  No If yes, please provide dates below.

Disability began / / Light duty / / Regular work / /

Will there be any permanent defect or disfigurement?  Yes  No  Unknown

Has patient reached maximum medical improvement?  Yes  No Date / /

### Attending Physician

Attending Physician's Name				
Address		City	State	Zip Code

I certify that I personally examined and treated this patient.

SIGNATURE OF PHYSICIAN

DATE



### Attending Physician's Report

The treating physician completes this form and the report provides specific information including the date of accident, diagnosis, prognosis, the disability period(s), and the extent of any permanent disability. This form must be signed by the treating physician.

### Instructions

This form may be filed electronically through the Commission's WebFile system at [webfile.workcomp.virginia.gov](http://webfile.workcomp.virginia.gov). To file electronically, the user must have a valid and active WebFile account. This form may also be filed by mail or in-person at 333 E. Franklin St., Richmond, Virginia 23219.

For questions or assistance with completing this form, please contact the Virginia Workers' Compensation Commission toll-free at 1-877-664-2566.

### Amputation for Hand/Foot

In cases of amputation for hand/foot, the treating physician completes this form and may fill out the Amputation Chart located at [www.workcomp.virginia.gov/content/amputation-chart](http://www.workcomp.virginia.gov/content/amputation-chart).