WORKMAN'S COMPENSATION TRACKING

PATIENT NAME

DATE OF INJURY

COMPANY

INS. CO. CLAIM #: FAX #:

INSURANCE CONTACT PERSON:

Date of Visit	Date NoC faxed	Date RtW faxed	Affidavit DUE Date	Next Appt. Date	*Comments*

NOTES:

NOTIFICATION OF CLAIM OF COMPENSABLE INJURY

TO BE SUBMITTED TO INSURER WITHIN THREE (3) DAYS OF INITIAL VISIT WITH A COPY TO THE EMPLOYEE AND HIS OR HER ATTORNEY

DWC/MAB #: _____ ***INSURER'S #:*** _____

EMPLOYEE INFORMATION:

Social security # _____

Name _____

Address _____

City _____ State_____ Zip _____

Phone _____ DOB _____

EMPLOYER INFORMATION:

FEIN # _____

Name _____

Address _____

City _____ State_____ Zip _____

Phone _____

INSURANCE CARRIER:

Name _____

Address _____

City _____ State_____ Zip _____

Phone _____

Injury Date _____

ADJUSTING COMPANY:

Name _____

Address _____

City _____ State_____ Zip _____

Phone _____

IF THE IDENTITY OF THE INSURER IS UNKNOWN, CONTACT THE DIVISION OF WORKERS' COMPENSATION AT (401) 462-8116 FOR THE INFORMATION. SECTION 28-33-8(b) OF THE RHODE ISLAND WORKERS' COMPENSATION ACT PROVIDES FOR A $20.00 FEE TO BE CHARGED FOR THE TIMELY FILING OF THIS FORM.

1. In the patient's own words, relate how the injury happened: _____

_____

2. Patient's complaints (nature and location of injury) : _____

_____

3. Initial diagnosis: _____

4. Description of employee's job: _____

_____

5a. Is the patient released to work, full duty? ☐ Yes ☐ No

If the answer is YES, there is no need to submit a return to work form.

5b. If the answer to 5a is NO, indicate anticipated return to work date:

Modified RTW date: _____ Regular RTW date: _____

6. Date(s) of examination on which this report is based: _____

Are you continuing treatment? ☐ Yes ☐ No

If YES, when will patient be seen again? _____

Physician's Signature _____ Date _____

Physician's Name _____ Treatment Facility NORTH SMITHFIELD URGENT CARE

~~Physician's Assistant Signature~~ _____

Supervising Physician's Name _____ PHONE: 401-768-3400 / FAX: 401-768-3402

Physician's Address _____ 594 Great Road, Suite 102A, North Smithfield, RI 02896

PHYSICIAN'S NOTICE OF RELEASE TO WORK

Submit to insurer within three (3) days of release to work with a copy to the employee and his or her attorney.

DWC/MAB File # _____ **Insurer's File #** _____

Employee/Patient Information:

Social Security # _____
Name _____
Address _____
City, State, Zip _____
Phone _____
Date of Birth _____

Injury Date: _____

Employer Information:

FEIN # _____
Name _____
Address _____
City, State, Zip _____
Phone _____

Insurance Carrier:

Name _____
Address _____
City, State, Zip _____
Phone _____

Adjusting Company:

Name _____
Address _____
City, State, Zip _____
Phone _____

If the insurer is not known, contact the Division of Workers' Compensation at (401) 462-8100. Section 28-33-8(b) of the RI Workers' Compensation Act provides for a $20.00 fee to be charged for the timely filing of this form.

This medical report is rendered pursuant to Section 28-33-8 of the RI Workers' Compensation Act.

This is to certify that the above named employee is able to return to work on _____

To (check one) ☐ Regular duty, no restrictions ☐ Modified duty, limitations as follow:

Indicate modified duty restrictions:

- ☐ No operating heavy machinery or vehicles
- ☐ No repetitive climbing ladders or stairs
- ☐ May lift up to _____ pounds only
- ☐ No reaching above shoulders
- ☐ No repetitive twisting, bending, squatting
- ☐ No repetitive stooping, kneeling
- ☐ Alternate standing/sitting
- ☐ No work involving use of right/left _____
- ☐ Sit down work only
- ☐ Keep wound clean and dry
- ☐ Other _____

Date of next visit: _____

☐ The patient will require no further medical items or medical services associated with this claim.

This certification is based on the medical examination performed on _____

Physician's signature _____ Date _____

Physician's name _____

North Smithfield *Urgent Care*
594 Great Road, Suite 102A
North Smithfield, RI 02896
Tel: 401-768-3400 / Fax: 401-768-3402