Mississippi Workers' Compensation Commission

MEDICAL REPORT

THE USE OF THIS FORM IS REQUIRED UNDER THE PROVISIONS OF THE MISSISSIPPI WORKERS' COMPENSATION LAW AND MUST BE FILED WITH CARRIER IMMEDIATELY.

PRELIMINARY REPORT Q
PROGRESS REPORT Q
FINAL REPORT Q

PRINT OR TYPE

Failure to submit this report will jeopardize payment of fees.

MWCC #	CARRIER FILE #

GENERAL INFORMATION (ALL REPORTS)

EMPLOYEE (NAME AND ADDRESS - INCLUDE CITY, STATE and ZIP)	SOCIAL SECURITY NUMBER			DATE OF BIRTH
	AGE	SEX	DATE OF INJURY	DATE DISABILITY BEGAN

EMPLOYER (NAME AND ADDRESS - INCLUDE CITY, STATE and ZIP)	INSURANCE CARRIER (NAME AND ADDRESS - INCLUDE CITY, STATE and ZIP)
FEIN:	FEIN:

DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (RELATE ITEMS 1, 2, 3 OR 4 TO ITEM (E) DIAGNOSIS CODE BY LINE)

1
2
3
4

(A) DATE(S) OF SERVICE FROM	TO	(B) Place of Service	(C) Type of Service	(D) PROCEDURES, SERVICES OR SUPPLIES (Explain unusual Circumstances) ***INCLUDE DRUGS PRESCRIBED***	(E) DIAG CODE	(F) $ CHARGES	(G) DAYS OR UNITS

PRELIM./PROGRESS

PATIENT'S DESCRIPTION OF ACCIDENT OR OCCUPATIONAL ILLNESS	HOSPITAL NAME/ADDRESS IF HOSPITALIZED

NOTE ANY CHANGE IN DIAGNOSIS MADE ON ANY PREVIOUS REPORT AND EXPLAIN.	SERVICES ENGAGED BY

IF PATIENT HAS A PRIOR IMPAIRMENT CONTRIBUTING TO PRESENT DISABILITY, GIVE PARTICULARS.	IS CONDITION WORK RELATED? IF SO, DESCRIBE	DATE FIRST TREATMENT
		EXPECTED DATE MMI

FINAL REPORT

DATE PATIENT REFUSED TREATMENT	DATE PATIENT STOP TREAT. W/O ORDER	DATE DISCHARGED AS CURED/MAX MED IMP.	DATE ABLE TO RETURN WORK	VOCATIONAL REHABILITATION WILL BE UNLIKELY	PROBABLE	NECESSARY
			Q LIGHT Q NORMAL			

IS PATIENT CAPABLE OF DOING SIMILAR/OTHER EMPLOYMENT AS BEFORE INJURED? IF NO, WHY?

DOES PATIENT HAVE ANY PERMANENT DISABILITY RESULTING FROM THIS INJURY? IF SO, GIVE PART OF BODY AND ***PERCENT OF DISABILITY*** (INCLUDING VISION AND HEARING IF AFFECTED). _____ %

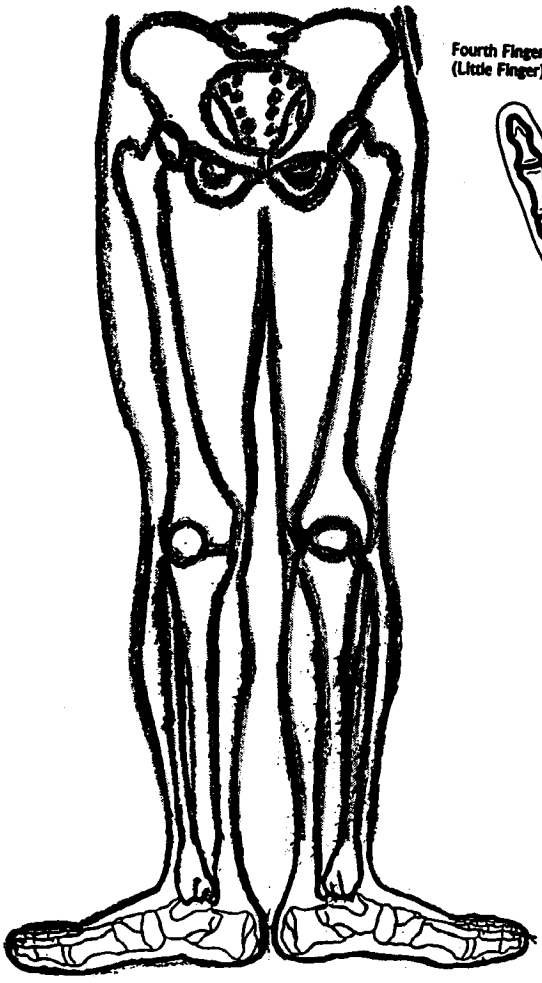
PHYSICAL RESTRICTIONS, IF ANY

WAS THERE FACIAL OR HEAD DISFIGUREMENT? IF YES, DESCRIBE FULLY.

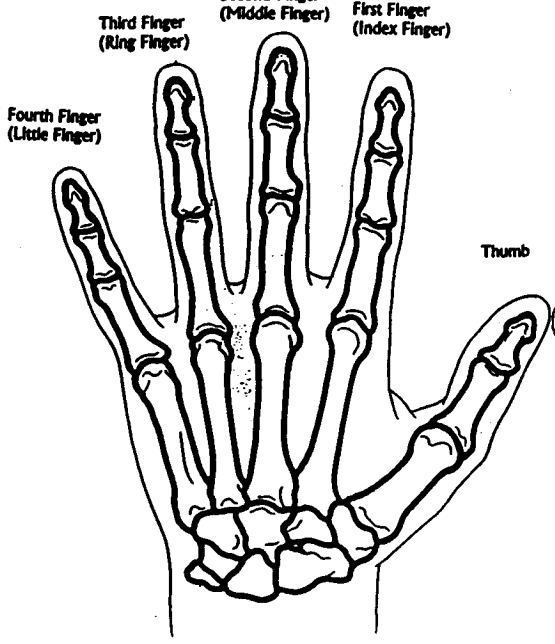
GEN./ALL

DOCTOR'S NAME AND ADDRESS	DOCTOR'S ID NUMBER	DATE
	SIGNATURE	

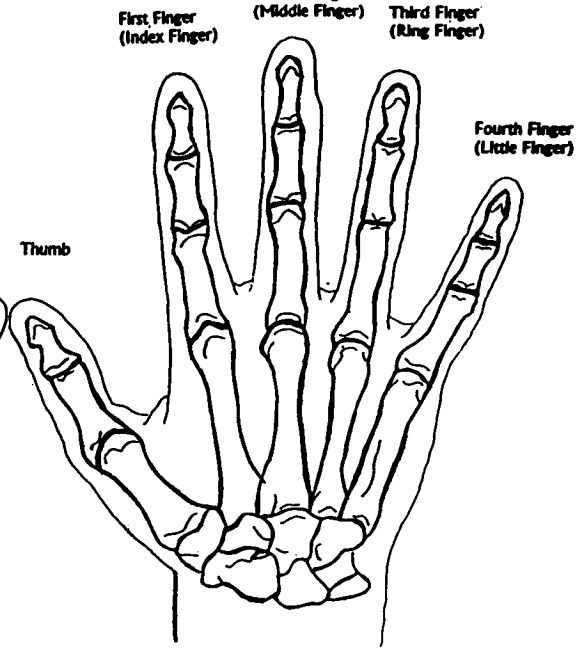
AMPUTATION CHART ON BACK



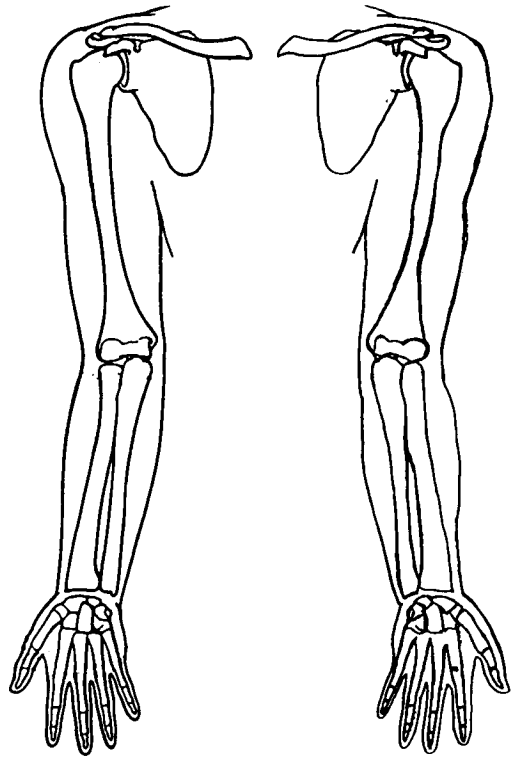
Right Leg Left Leg



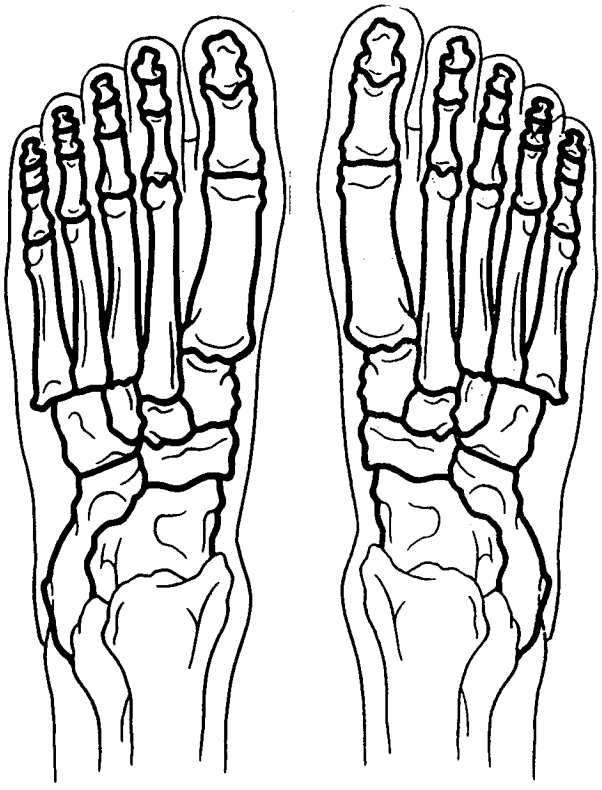
Left Hand



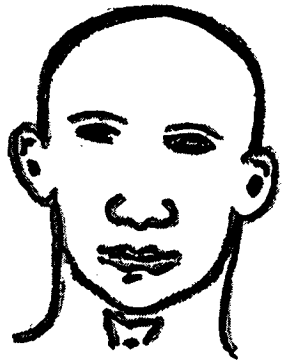
Right Hand



Right Arm Left Arm



Left Foot Right Foot



Mark Facial or Head Disfigurement