New York State Unified Court System

Certificate of Attending Physician

EMPLOYEE AUTHORIZATION: Sign and Date below before submitting this form to your physician

I hereby authorize any Physician or Surgeon to release any information requested with respect to this certificate.

_____ _____
Employee's Signature Date

NOTICE TO PHYSICIAN

This certificate is being submitted by a patient in support of a request for a workers' compensation benefit.

An employee's request will not be processed until satisfactory medical documentation is received. Your cooperation in providing a detailed explanation of the employee's condition and treatment and prognosis for recovery is essential for processing the benefit.

Return the completed form to the HR Workers' Compensation Unit:

- by scan/email to: WCUnit@nycourts.gov OR
- by fax to: (212) 952-7208 OR
- by mail to: HR Workers' Compensation Unit, 25 Beaver St, Room 1058, New York, NY 10004

PATIENT INFORMATION

Name: _____ _____ ____
Last First MI

Date of injury/onset of illness: ____/____/____ Job Title: _____

PHYSICIAN INFORMATION

Name: _____ _____ ____
Last First MI

Office Address: _____ _____ ____ _____
Street Address City State Zip

Office Phone: (_____) _____ Fax: (_____) _____

You are a (check one) ❑ Physician ❑ Orthopedist ❑ Podiatrist ❑ Chiropractor ❑ Other _____

PATIENT HISTORY

How did you learn about the injury/illness? (*check one*) ❑ Patient ❑ Medical Records ❑ Other (*specify*):

_____

Did another health provider treat this injury/illness including hospitalization and/or surgery? ❑ Yes ❑ No

If yes, give details: _____

_____

Have you previously treated this patient for a similar work-related injury/illness? ❑ Yes ❑ No

If yes, give details: _____

_____

Based on the patient's history, and if applicable, are there any changes in the patient's condition since last report?

_____

_____

Does the patient's medical history reveal any pre-existing condition(s) that may affect the treatment and/or prognosis? ❑ Yes ❑ No

If yes, give details: _____

_____

EXAM INFORMATION

Date(s) of Examination: _____

Patient complaints: *Check all that apply and identify specific affected body part(s)*

❑ Numbness/Tingling _____ ❑ Swelling _____

❑ Pain _____ ❑ Weakness _____

❑ Stiffness _____ ❑ Other *(specify)* _____

Type/nature of injury: *Check all that apply and identify specific affected body part(s)*

❑ Abrasion _____ ❑ Infection _____

❑ Amputation _____ ❑ Inhalation _____

❑ Avulsion _____ ❑ Laceration _____

❑ Bite _____ ❑ Needle Stick _____

❑ Burn _____ ❑ Poisoning/Toxic Effects _____

❑ Contusion/Hematoma _____ ❑ Psychological _____

❑ Crush Injury _____ ❑ Puncture Wound _____

❑ Dermatitis _____ ❑ Repetitive Strain Injury _____

❑ Dislocation _____ ❑ Spinal Cord _____

❑ Fracture _____ ❑ Sprain/Strain _____

❑ Hearing Loss _____ ❑ Torn Ligament, Tendon, or Muscle _____

❑ Hernia _____ ❑ Vision Loss _____

❑ Other (specify): _____

Physical Examination: *Check all relevant objective findings and identify specific affected body part(s)*

❑ None at present

❑ Bruising _____ ❑ Neuromuscular Findings:

❑ Burns _____ ❑ Abnormal/Restricted ROM

❑ Crepitation _____ ❑ Active ROM _____

❑ Deformity _____ ❑ Passive ROM _____

❑ Edema _____ ❑ Gait _____

❑ Hematoma/Lump/Swelling _____ ❑ Palpable Muscle Spasm _____

❑ Joint Effusion _____ ❑ Reflexes _____

❑ Laceration _____ ❑ Sensation _____

❑ Pain/Tenderness _____ ❑ Strength _____

❑ Scar _____ ❑ Wasting/Atrophy _____

❑ Other Findings _____

Describe any diagnostic test(s) rendered at this visit: _____

_____

Describe any treatment(s) rendered at this visit: _____

_____

PHYSICIAN'S OPINION

Was the incident that the patient described the probable medical cause of this injury/illness? ❑ Yes ❑ No

Are the patent's complaints consistent with his/her history of the injury/illness? ❑ Yes ❑ No

Is the patient's history of the injury/illness consistent with your objective findings? ❑ Yes ❑ No

What is the percentage (0-100%) of temporary impairment? _____%

WORK STATUS

Has the patient missed work because of the injury/illness? ❑ Yes ❑ No

If yes, patient first missed work: _____/_____/_____

Is patient currently working? ❑ Yes ❑ No

If yes, did the patient return to: ❑ usual work activities ❑ restricted work activities

Can the patient return to work? *check <u>only</u> one*

❑ The patient cannot return to work (explain): _____

_____

❑ The patient can return to work without restrictions on: _____/_____/_____

❑ The patient can return to work with restrictions on: _____/_____/_____

Describe the restrictions: _____

_____

_____

How long will these restrictions apply?

❑1–2 days ❑3–7 days ❑8–14 days ❑15+ days ❑Unknown at this time ❑Other _____

PLAN OF CARE

What is the proposed treatment? _____

_____

_____

Medication:

- list medication(s) prescribed: _____
- list over the counter medication(s) advised: _____
- Medication restrictions: ❑ None ❑ May affect patient's ability to return to work. Explain:

_____

_____

PHYSICIAN'S CERTIFICATION

I certify that the information contained herein is true and correct to the best of my knowledge.

_____	_____	_____/_____/_____
Physician's Name (please print)	Signature	Date