



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?

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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)*

- |  |  |
|--|--|
| <input type="checkbox"/> Numbness/Tingling _____ | <input type="checkbox"/> Swelling _____        |
| <input type="checkbox"/> Pain _____              | <input type="checkbox"/> Weakness _____        |
| <input type="checkbox"/> Stiffness _____         | <input type="checkbox"/> Other (specify) _____ |

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

- |   |   |
|---|---|
| <input type="checkbox"/> Abrasion _____           | <input type="checkbox"/> Infection _____                        |
| <input type="checkbox"/> Amputation _____         | <input type="checkbox"/> Inhalation _____                       |
| <input type="checkbox"/> Avulsion _____           | <input type="checkbox"/> Laceration _____                       |
| <input type="checkbox"/> Bite _____               | <input type="checkbox"/> Needle Stick _____                     |
| <input type="checkbox"/> Burn _____               | <input type="checkbox"/> Poisoning/Toxic Effects _____          |
| <input type="checkbox"/> Contusion/Hematoma _____ | <input type="checkbox"/> Psychological _____                    |
| <input type="checkbox"/> Crush Injury _____       | <input type="checkbox"/> Puncture Wound _____                   |
| <input type="checkbox"/> Dermatitis _____         | <input type="checkbox"/> Repetitive Strain Injury _____         |
| <input type="checkbox"/> Dislocation _____        | <input type="checkbox"/> Spinal Cord _____                      |
| <input type="checkbox"/> Fracture _____           | <input type="checkbox"/> Sprain/Strain _____                    |
| <input type="checkbox"/> Hearing Loss _____       | <input type="checkbox"/> Torn Ligament, Tendon, or Muscle _____ |
| <input type="checkbox"/> Hernia _____             | <input type="checkbox"/> Vision Loss _____                      |
| <input type="checkbox"/> Other (specify): _____   |   |

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

- |  |  |
|--|--|
| <input type="checkbox"/> None at present   |  |
| <input type="checkbox"/> Bruising _____    | <input type="checkbox"/> Neuromuscular Findings: |
| <input type="checkbox"/> Burns _____       | <input type="checkbox"/> Abnormal/Restricted ROM |
| <input type="checkbox"/> Crepitation _____ | <input type="checkbox"/> Active ROM _____        |
| <input type="checkbox"/> Deformity _____   | <input type="checkbox"/> 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 patient'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 only 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    /    /