Merrimack Valley Occupational Health, 171 Pleasant St., Concord, NH 03301

NEW HAMPSHIRE WORKERS' COMPENSATION MEDICAL FORM

This form must be completed at each health professional visit (MD, DO, DC or DDS) and must be filed with the workers' compensation insurance carrier within 10 days of the treatment (first aid excluded). Failure to comply and complete this form shall result in the provider not being reimbursed for services rendered and may result in a civil penalty of up to $2,500.

In compliance with RSA 281-A:23-b, the employer with 5 or more employees must provide temporary alternative/transitional work opportunities to all employees temporarily disabled by a work related injury or illness.

Employee_____ Employer_____

SS#_____ Work telephone #_____

Occupation_____ Employer contact_____

Date last worked_____ Employer address_____

W.C. insurer_____ _____

HEALTH PROFESSIONAL TO COMPLETE

☐ Initial visit ☐ Follow-up visit Date of Injury_____ Time_____

Worker's statement of the incident_____

Worker's complaints_____

Diagnosis/Prognosis_____

Treatment plan_____

_____

In your opinion is this injury and disability as a result of injury described above? ☐ Yes ☐ No ☐ Unclear

EMPLOYEE WORK CAPABILITY

☐ Continue Working Can return to work: ☐ Yes Date_____ ☐ No

☐ Full Duty ☐ With Modification. If so, for what duration?_____

Employee Can	No Restrictions		Frequently	Occasionally	Unable to
bend					
kneel					
squat					
climb					
stand					
walk					
sit					
reach					
drive					
do fine motor					
No repetitive motions		Wrist	Elbow	Shoulder	Ankle
	Right				
	Left				

Employee can lift/carry maximally _____ lbs.
Employee can lift/carry frequently _____lbs.

Employee can work a maximum of #_____ hours/day, #_____days/wk.
What special accommodations are required?_____
_____

Other_____
Has employee reached maximum medical improvement?
☐ Yes ☐ No
Has injury caused permanent impairment?
☐ Yes ☐ No ☐ Undetermined

ALL MEDICAL NOTES MUST BE ATTACHED TO BILL

I certify that the narrative descriptions of the principal and secondary diagnosis and the major procedures performed are accurate and complete to the best of my knowledge.

_____ David F. Lake, APRN_____ ____(603) 228-3500_____
Provider's signature Provider's Printed name Provider's telephone #

__200960500_____ _____
Federal ID# Date of Visit

MEDICAL AUTHORIZATION: The act of the worker in applying for workers' compensation benefits constitutes authorization to any physician, hospital, chiropractor, or other medical vendor to supply all relevant medical information regarding the worker's occupational injury or illness to the insurer, the worker's employer, the worker's representative, and the department. Medical information relevant to a claim includes a past history of complaints of, or treatment of, a condition similar to that presented in the claim. [281-A:23 V(a)]

75 WCA-1 (06/94) White – Insurer/Managed Care Yellow – Provider Pink – Employee/Employer