Attending Physician's Report

U.S. Department of Labor
Employment Standards Administration
Office of Workers' Compensation Programs

OMB No. 1215-0103
Expires: 08-31-02

Record of Examination

1. Patient's name Last First Middle
2. Date of Injury mo. day yr.
3. OWCP File Number

4. What history of injury (including disease) did patient give you?

5. Is there any history or evidence of concurrent or pre-existing injury or disease or physical impairment? (If yes, please describe) ☐ Yes ☐ No — ICD-9 Code

6. What are your findings? (Include results of X-Rays, laboratory reports, etc.)

7. What is your diagnosis? — ICD-9 Code

8. Do you believe the condition found was caused or aggravated by an employment activity? (Please explain answer) ☐ Yes ☐ No

9. Did injury require hospitalization? If no, go to item #13 ☐ Yes ☐ No
10. Date of admission mo. day yr.
11. Date of discharge mo. day yr.
12. Additional Hospitalization required If Yes, describe in "Remarks" (Item 25) ☐ Yes ☐ No

13. What treatment did you provide?

14. Date of first examination mo. day yr.
15. Date(s) of treatment mo. day yr. mo. day yr. mo. day yr.
16. Date of discharge from treatment mo. day yr.

17. Period of total disability From mo. day yr. Thru mo. day yr.
18. Period of Partial Disability From mo. day yr. Thru mo. day yr.
19. Date employee able to resume light work mo. day yr.

20. Date employee is able to resume regular work mo. day yr.
21. Has employee been advised that he/she can return to work? ☐ Yes ☐ No
22. If yes, on what date was he/she advised? mo. day yr.

23. If employee is able to resume only light work, indicate the extent of physical limitations and the type of work that could reasonably be performed with these limitations. (Continue in item #25 if necessary.)
24. Are any permanent effects expected as a result of this injury? If yes, describe in item #25. ☐ Yes ☐ No

25. Remarks

26. If you have referred the employee to another physician provide the following:
Name
Address
City State ZIP
Specialty
27. What was the reason for this referral? ☐ Consultation ☐ Treatment

Signature

28. I certify that the statements in response to the questions asked above are true, complete and correct to the best of my knowledge. Further, I understand that any false or misleading statement or any misrepresentation or concealment of material fact which is knowingly made may subject me to felony criminal prosecution.

Signature of Physician _____ Date _____

29. Name of Physician
Address
City State ZIP
30. Tax ID Number
31. Do you specialize? ☐ Yes ☐ No
32. If yes, indicate specialty

Form CA-20
Rev. Nov. 1999

TO BE USED IN PLACE OF CA16 MEDICAL