IMMEDIATELY UPON COMPLETION PLEASE
MAIL COPIES AS SHOWN BELOW

WORKER'S & PHYSICIAN'S REPORT OF INJURY
INDUSTRIAL COMMISSION OF ARIZONA

P.O. BOX 19070 • PHOENIX, ARIZONA 85005

INJURED WORKER'S RIGHT TO CHOOSE DOCTOR

An employer who is not self-insured can direct you to a doctor of their choice for ONE visit. After the **ONE** visit, you may report to a doctor of your choice. **REMEMBER:** If you make a **SECOND** visit to the employer's doctor, you have established that doctor as your treating doctor. If your employer is self-insured, you may not be allowed to change doctors. **SEE INFORMATION SHEET ATTACHED TO THIS FORM FOR FURTHER INSTRUCTIONS.**

WORKER'S REPORT

NAME OF INJURED WORKER
LAST NAME FIRST M.I.

SOCIAL SECURITY NO.

PHONE NO.

ICA USE ONLY
INJURY CODE: _____

1.
2. ADDRESS CITY STATE ZIP
3. DATE OF BIRTH 4. SEX: MALE ○ FEMALE ○
5. SINGLE ○ WIDOWED ○ DIVORCED ○ MARRIED ○ IF SO, IS SPOUSE EMPLOYED YES ○ NO ○
6. OCCUPATION WHEN INJURED DATE OF INJURY TIME OF INJURY
7. EMPLOYER'S NAME PHONE NO.
8. OFFICE ADDRESS CITY STATE ZIP
9. EMPLOYER'S INSURANCE CARRIER POLICY NO.
10. MAILING ADDRESS
11. DESCRIBE **WHERE** AND **HOW** ACCIDENT OR CAUSE OF DISABILITY OCCURRED (INCLUDING LOCATION AND/OR DEPARTMENT)

BY THIS INSTRUMENT I MAKE APPLICATION FOR ALL BENEFITS TO WHICH I MAY BE ENTITLED UNDER THE LAW AND I DO HEREBY CERTIFY, WITH FULL KNOWLEDGE THAT IT IS A CRIME TO MAKE WILLFUL, FALSE STATEMENTS TO OBTAIN COMPENSATION, THAT ALL OF MY STATEMENTS ON THIS FORM ARE TRUE, ACCURATE AND COMPLETE. I UNDERSTAND I MUST FOLLOW THE INSTRUCTIONS OF MY DOCTOR AND MUST HAVE WRITTEN APPROVAL FROM THE INDUSTRIAL COMMISSION TO LEAVE THE STATE OF ARIZONA OR MY LOCALITY FOR MORE THAN 14 DAYS, FAILURE TO DO SO MAY CAUSE FORFEITURE OF COMPENSATION BENEFITS.

DATE OF SIGNING AT CITY STATE

IMPORTANT: INJURED WORKER'S SIGNATURE REQUIRED HERE **X** _____

PHYSICIAN'S INITIAL REPORT

12. DATE FIRST TREATMENT HOUR 13. LOCATION: HOSPITAL ○ OFFICE ○ OTHER ○
14. DATE WORKING DISABILITY BEGAN 15. WHO ENGAGED YOUR SERVICES? PATIENT ○ EMPLOYER ○ OTHER ○
16. WAS PATIENT TREATED BY ANYONE ELSE? YES ○ NO ○ IF YES, BY WHOM?
17. COMPLAINTS AND PHYSICAL FINDINGS IN DETAIL:
18. ICD- CODE DIAGNOSIS:
19. DESCRIBE ANY PRE-EXISTING IMPAIRMENT OR DISEASE AFFECTING PRESENT CONDITION
20. PATIENT IS RIGHT ○ LEFT ○ HANDED
21. DESCRIBE TREATMENT GIVEN BY YOU:
22. WERE X-RAYS TAKEN? YES ○ NO ○ IF YES, BY WHOM? WHEN
23. WAS LABORATORY WORK DONE? YES ○ NO ○ IF YES, BY WHOM WHEN
24. X-RAY DIAGNOSIS (ATTACH ROENTGENOLOGICAL REPORT FORM)
25. WAS PATIENT HOSPITALIZED? YES ○ NO ○ IF YES, WHERE
26. DATE OF ADMISSION TO HOSPITAL 27. DATE OF DISCHARGE
28. IS FURTHER TREATMENT NEEDED? YES ○ NO ○ IF YES, FOR HOW LONG
29. IS PATIENT, AS A RESULT OF CONDITIONS DUE TO THIS ACCIDENT: (A) SUBJECT TO SUSTAIN A PERMANENT DEFECT OF IMPAIRMENT? YES ○ NO ○
(B) ABLE TO DO THE SAME TYPE OF WORK HE PERFORMED AT TIME OF INJURY? YES ○ NO ○ IF YES, DATE ABLE IF NOT, ANTICIPATED DATE
(C) ABLE TO DO A LIGHTER OR DIFFERENT TYPE OF WORK THAN PERFORMED AT TIME OF INJURY? YES ○ NO ○ IF YES, DATE ABLE
IF NOT, ANTICIPATED DATE ABLE
30. REMARKS:

NAME OF PHYSICIAN BILLING CODE NO.
ADDRESS ZIP PHONE
IRS. NO. PROFESSIONAL CORP? YES ○ NO ○
DATE OF THIS REPORT PHYSICIAN'S SIGNATURE REQUIRED HERE **X** _____

THIS FORM APPROVED BY THE INDUSTRIAL COMMISSION OF ARIZONA FOR CARRIER USE.