## WORKER'S COMPENSATION FOLLOW-UP INJURY REPORT ENTIRA FAMILY CLINICS

Today's Date:						
Employee Name				1	Date of Birth	
Employer Name and	Address					
Company Contact Person (Supervisor)			C	City ompany Phone		Zip
Date of Initial Report of Injury			Date of previous visit			
Date of Initial Report of Injury			Date of previous visit			_
ASSESSMENT (	OF INHIRV.	Physician Com	ımants:			
ASSESSMENT	OF INJUNT-	1 Hysician Com	mients.			
			_			
Diagnosis:			Permanent dis	sability likely	Yes No	Do not know
DID THIS INJURY I	PREVENT THE	EMPLOYEE FRO	M WORKING?	Yes l	No	
If yes, the employee i	is / was:					
in yes, the employee						
		through				
A. Totally unab	ole to work from	through	 ow Physical Can	abilities) from	through	
A. Totally unab B. Able to return	ole to work from grant to work with re	estrictions (see bel	ow Physical Capa	abilities) from	through_	·
A. Totally unab B. Able to return C. Able to work	ole to work from on to work with real k without restricts	estrictions (see beloions as of	ow Physical Capa	abilities) from	through_	
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Provider signature:\_\_\_\_\_

\_Date:\_\_\_\_\_