Department of Workforce Development
Worker's Compensation Division
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PRACTITIONER'S REPORT ON ACCIDENT OR INDUSTRIAL DISEASE IN LIEU OF TESTIMONY

FILED ON BEHALF OF: ☐ **EMPLOYEE** ☐ **EMPLOYER OR INSURANCE CARRIER**

*Provision of your Social Security Number (SSN) is voluntary. Failure to provide it may result in an information processing delay.
The Department of Workforce Development (DWD) administers the Worker's Compensation Act, Chapter 102 Wis. Stats. The purpose of this form is to assist with the procurement of information related to or required by Chapter 102. Completion of this form is voluntary and failure to complete said form may result in a delay in the administration of Chapter 102. DWD may use the personally identifiable information (PII) it obtains from you on this form for purposes other than those for which it is being collected.

1. WC Claim Number	Employee Name
Employee Social Security Number*	Employee Address

2. Employer Name	3. Date of Traumatic Event
Employer Address	Worker's Compensation Insurance Carrier

4. Describe the accidental event or work exposure to which the patient attributes his/her condition. (A copy of medical history or notes containing this information will suffice if complete.)

5. Give a complete description of physical or mental disability and diagnosis. (A copy of the medical history or notes containing this information will suffice if complete and limited to the work injury.)

6. Did you treat the patient? If so, between what dates? ☐ Yes ☐ No and	7. Date of last examination or evaluation	8. Date disability from work began

9. Date injured was or will be able to return to a limited type of work:
State any temporary limitations.

10. Date injured was or will be able to return to full time work subject only to permanent limitations:
State any permanent limitations.

11. In your opinion, is it probable that the event in Item 4 directly caused the disability? ☐ Yes ☐ No	12. If not directly, is it probable that the event described in Item 4 caused the disability by precipitation, aggravation and acceleration of a pre-existing progressively deteriorating or degenerative condition beyond normal progression? ☐ Yes ☐ No
13. If the patient suffers from a condition caused by an appreciable period of work place exposure (from Item 4), was that exposure either the sole cause of the condition, or at least a material contributory causative factor in the condition's onset or progression? ☐ Yes ☐ No	If Yes, give date disability from work began:

14. Has accident or industrial disease resulted in any permanent disability? ☐ Yes ☐ No

15. Estimate percentage of permanent disability to the member, eye or ear involved, or compare to permanent total disability if injury is to torso or head, caused by the accident or work exposure described in Item 4.

16. What elements constitute permanent disability (such as limitation of motion, deformity, weakness, pain, lack of endurance or components of illness, e.g., isoiconias, photo toxicity, liver disease)? If limitation of motion, describe nature and percentage of limitation of each part of each member affected. (Make estimates on voluntary, not passive motions.) If amputation, state exact point bone was amputated and whether stump is tender or hardy.

17. What is the prognosis of this disability? If guarded, please explain:

18. Do you expect that any further treatment will be necessary for this condition?

☐ Yes ☐ No If Yes, explain:

19. Prior to this accident or illness, did employee have any permanent disability?

☐ Yes ☐ No If Yes, explain:

20. I am a practitioner licensed in and practicing in Wisconsin.

Practitioner Typed or Printed Name:

Practitioner Address (Street or P.O. Box):

Practitioner Address (City, State and Zip Code):

Practitioner Phone Number:
( ) -

College:

If not licensed and practicing in Wisconsin, state where practitioner is licensed and practicing:

CERTIFICATION

I certify, subject to the penalty of fine and/or imprisonment, as provided in Sec. 943.39 of the Wisconsin Statutes, that the above report truly and correctly sets forth the history, my findings, diagnosis and opinion.

_____

Signature of Practitioner Date Signed

IMPORTANT: Section 102.17(1)(d) of the Wisconsin Statutes provides that the contents of certified medical and surgical reports presented by parties shall constitute prima facie evidence as to the matter contained therein. Reports must be filed with the department and the other parties fifteen days prior to the date of hearing to be acceptable as evidence. If not so filed, it will be necessary to produce the doctor to give oral testimony at the time of hearing.