Worker's Compensation Form No. 2

Commission's Number	File: _____ Carrier: _____ Employer: _____
	Carrier's File No. _____

(The spaces above not to be filled in by Employer)

STANDARD FORM FOR

SURGEON'S REPORT

COMMISSIONER OF LABOR
VIRGIN ISLANDS OF THE UNITED STATES

The Patient

1. Name of Injured Person: _____ Age _____ Sex _____

2. Address: No. & St. _____ City or Town _____ Virgin Islands of USA

3. Name & Address of Employer: _____

The Accident

4. Date of Accident: _____ Hour _____ AM PM (Circle One) Date Disability Began _____

5. State in patient's own words where and how accident occurred:

_____

_____

_____

The Injury

6. Give accurate description of nature and extent of injury and state your objective findings:

_____

_____

7. Will the injury result in (a) Permanent defect? _____ If so, what? _____

(b) Facial or head disfigurement? _____

8. Is accident referred to the only cause of patient's condition? _____ If not, state contributing causes _____

_____

9. Is patient suffering from any disease of the heart, lungs, brains, kidneys, blood, vascular system or any other disabling condition due to this accident? _____
Give Particulars: _____

10. Has patient any physical impairment due to previous accident or disease? _____ Give Particulars: _____

11. Has normal recovery been delayed for any reason? _____ Give Particulars: _____

11b. Name and type of medication Prescribed for this injury: _____

Treatment

12. Date of your treatment: _____ Who engaged your services? _____

13. Describe treatment given by you: _____

14. Were x-rays taken? _____ By Whom? _____ When? _____
(Name and Address)

15. X-rays diagnosis _____

16. Was patient treated by anyone else? _____ If so, by whom? _____ When? _____
(Name and Address)

17. Was Patient hospitalized? _____ Name and Address of Hospital: _____

18. Date of admission to hospital: _____ Date of Discharge? _____ Is further treatment needed? _____ For how long? _____

Disability

19. Patient was/will be able to resume light duty on: _____

20. Patient was/will be able to resume work on: _____

21. If death ensued give date _____

Signature

REMARKS: (Give information of value not included above)

_____

I am a duly licensed physician in the State of _____

I graduated from _____ Medical School in _____ Year _____

Date of this Report: _____ Signed: _____

Address: _____

This Report must be signed personally by Physician.