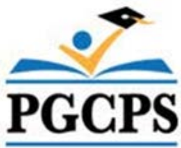

Mailing Address:
Prince George's County Public Schools
Risk Management Office
14201 School Lane, Temp Unit #470
Upper Marlboro, MD 20772
Main: (301) 952-6076

Medical Payments:
CorVel Corporation
P.O. Box 7328, Largo, MD 20792
Phone: (301) 925-4024

WORKERS' COMPENSATION
ATTENDING PHYSICIAN'S STATEMENT

This form is to be completed by the attending physician for each appointment.

Please Complete and Fax or Email to:
Risk Management Office
Fax # (301) 952-6027
workers.compensation@pgcps.org

The named individual below has filed a claim for benefits as a result of the Injury/Illness for which he/she is currently or has been under your care. Please complete the following at your earliest convenience and fax to 301-952-6027 or email to workers.compensation@pgcps.org.

TO BE COMPLETED BY THE EMPLOYEE

NOTE: Disability Leave cannot be processed if this form is not received along with the Worker's Compensation Verification of Employee's Lost Time form by the Risk Management Office.

Name of Injured Employee: ____Employee (EIN):____________

Injured Employee Occupation: ____________________________________ Employee Phone #: (______)______-_______

School/Dept.: ____ Date of Injury: _______/_______/_________

Employee's Description of Accident/Injury:

____

____

Are you currently in the Transition-to-Work (TTW) Program? ☐ Yes ☐ No ☐ Not in the program but applied

TO BE COMPLETED BY PHYSICIAN – PART I

Date of this Examination: ________/________/________ (MM/DD/YY)

This is a (*please check one box*): ☐ First Report ☐ Progress Report ☐ Final Report

DIAGNOSIS AND CONCURRENT CONDITIONS: (If fracture or dislocation, describe nature and location. If sickness/illness describe the nature).____

____

Is further treatment needed? ☐ No ☐ Yes If Yes, for how long? _____ ☐ Days ☐ Weeks ☐ Months

NEXT APPOINTMENT DATE:

Patient has a return appointment on (date): ______/_____/ at (time): _______ ☐ AM ☐ PM

RETURN TO WORK STATUS

Transition-to-Work (TTW)/Light Duty maybe available to all eligible employees who can be released back to work with restrictions.

The patient is (check one):

☐ **UNABLE** to return to work in any capacity. **Effective Date(s): FROM: ___/_____/____ TO: _____/______/______**

(Proceed to sign and provide physician's stamp on page 2)

☐ **ABLE TO RETURN TO FULL DUTY/NO RESTRICTIONS** on (date): ______/______/_____

(Proceed to sign and provide physician's stamp on page 2)

☐ **ABLE TO RETURN WITH RESTRICTIONS** *(Complete Part II on page 2)*

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Phone: (301) 925-4024

Name of Injured Employee: ____

TO BE COMPLETED BY PHYSICIAN – PART II

RESTRICTIONS:

Effective Date(s): FROM: ______/______/_____ **TO:** _____/______/______

In accordance with this patient's physical capability, check all that apply:

☐ May resume work immediately, with the following restrictions:

☐ Sedentary work (sitting, occasional walking, standing, lifting less than 10 pounds)

☐ Light work (lifting less than 20 pounds) ☐ Medium work (lifting less than 50 pounds)

☐ Limited hours: _____hours per day ☐ Limited days: _____days per week

☐ Limited walking: ____ hours per day ☐ Limited standing: ____ hours per day

☐ Other:____

____

☐ Repetitive motion restrictions (specific to hand/arm injuries):

FREQUENCY	No Use	Occasional	Frequent	Constant
LEFT	☐	☐	☐	☐
RIGHT	☐	☐	☐	☐

I CERTIFY THAT THE ABOVE NAMED EMPLOYEE IS/WAS UNDER MY PROFESSIONAL CARE AND IS/WAS DISABLED FOR THE TIME PERIOD SPECIFIED ABOVE.

Name of Physician: _______________________________________

Signature of Physician: _______________________________________

Physician Address: _______________________________________

____

Physician Phone: (______) _____-_________ **Date Signed:** _____ /_______/______