

PHYSICIAN'S REPORT OF EMPLOYEE INJURY

Please be advised that this employer does not carry workers' compensation insurance. If it becomes necessary to refer to another doctor for treatment or opinion, please furnish such information to us prior to the referral for further authorization. All bills for authorized medical treatment or any inquiries concerning authorization for treatment should be directed to:

Attn: FAS, Inc.
P O BOX 2309
Addison, TX 75001-2309

Phone (866) 930-9493
Fax (972) 930-9479
EMAIL: CLAIMS@FASTPA.COM

EMPLOYER INFORMATION:

ADDRESS: _____ City: _____ State TX Zip: _____

PHONE: (_____) _____ FAX: (_____) _____ Policy# _____

Name of Injured Employee: _____

1. Date of injury: _____ Date first treatment rendered: _____

2. Description of incident: _____

3. Initial complaints: _____

4. Diagnosis: _____

5. Nature, extent, degree, body location of injury: _____

6. Treatment prescribed and prognosis: _____

7. Medication prescribed: _____

8. Probable length of hospital confinement: (if applicable) _____

9. X-rays taken Yes No If yes, results: Positive Negative _____

10. Lab test Yes No Describe procedure and results: _____

11. Was there any evidence of a prior or pre-existing injury or illness? Yes No If yes, what condition and to what extent may it contribute to incapacity or recovery? _____

12. In an effort to help employees return to work after an injury/illness more quickly, a limited duty program is available.

This Employee May return to work today without restrictions
 May return to work today with restrictions as indicated below for _____ days
 May not return to work until _____

13. If restrictions are required on or off the job, please indicate below:

- | | |
|---|--|
| <input type="checkbox"/> No standing over ___ hours | <input type="checkbox"/> No lifting over ___ lbs. |
| <input type="checkbox"/> No work requiring depth perception/driving | <input type="checkbox"/> No stooping/bending/twisting |
| <input type="checkbox"/> No reaching over shoulder height | <input type="checkbox"/> No walking over ___ hours |
| <input type="checkbox"/> No use R/L hand/upper extremities | <input type="checkbox"/> No weight-bearing R/L foot |
| <input type="checkbox"/> No climbing over ___ hours | <input type="checkbox"/> Must use crutches/splint |
| <input type="checkbox"/> No pushing/pulling over ___ lbs. | <input type="checkbox"/> No operation of machines/equipment |
| <input type="checkbox"/> Keep wound clean, dry ___ days | <input type="checkbox"/> No exposure to (specify, e.g. dust, chemical) _____ |

14a. Released to restricted duty: _____, 20_____. 14b. Released to regular duty: _____, 20_____

15. Will Employee require further medical treatment? Yes No If yes, date of next appointment _____, 20_____

16. Comments: _____

17. SIGNATURE OF PHYSICIAN; including degrees or credentials:
(I certify that the statements apply to this bill and are made a part thereof.)

SIGNED

DATE

18. PHYSICIAN'S ADDRESS, ZIP CODE & PHONE:

PIN#

GRP#