

TENNESSEE DEPARTMENT OF LABOR AND WORKFORCE DEVELOPMENT

**Division of Workers' Compensation
710 James Robertson Parkway, 2nd Floor
Nashville, Tennessee 37243-0661**

**STANDARD FORM MEDICAL REPORT
FOR INDUSTRIAL INJURIES**

A. PATIENT INFORMATION (Please type or neatly print all responses)

1. Name and Address

2. Social Security Number _____

3. Date of Exam(s) _____ 4. Date of Birth _____

5. Treating Physician []

Evaluating Physician []

- Upon Whose Request: _____

- Date of Request: _____

B. PATIENT HISTORY

Include pertinent history of injury along with current treatment, hospitalization(s) and period(s) claimant unable to work.

C. PHYSICAL EXAMINATION

Include chief complaints and state all findings relative to the injury.

D SUMMARY OF DIAGNOSTIC TESTING

In the space below, check the applicable blocks next to any test results which you reviewed and relied upon to base your medical assessments or conclusions. Be sure to show the date of each test, and summarize results. Attach copy(s) of reports, if available.

	DATE	SUMMARY OF RESULTS
[] X-RAY		
[] EMG		
[] CT SCAN		
[] MYELOGRAM		
[] MRI		
[] OTHERS		

E. SURGICAL PROCEDURES

Please specify (Attach Operative Note)

H. PHYSICIAN CERTIFICATION AND QUALIFICATIONS

I certify that the information furnished is correct and am aware that my signature attests to its accuracy. I further certify that all opinions are formulated within a reasonable degree of medical certainty. I further certify that my statement of qualifications is attached and that it is accurate.

Signature: _____ Dated: _____

Please type full name of physician _____

(Please attach a copy of the physicians statement of qualifications.)

CLAIMANT'S CHRONOLOGICAL MEDICAL HISTORY

Name & Address
of Physician or Hospital

Date Treatment Received

Nature of the injury or disease?
Part of body affected?
Still under doctor's care?

1.			
2.			
3.			
4.			

DATE

SIGNED _____
PLAINTIFF