WCC-2B

WORKERS COMPENSATION FUND
MEDICAL PRACTITIONER'S REPORT

(Made under regulation 21(2))

(This form shall be filled by medical practitioner)

A. TYPE OF MEDICAL REPORT (Mark (√) appropriately)

Occupational accident		Occupational disease		Death	

B. EMPLOYEE'S CONSENT

I, ……., wilfully agree my medical information contained herein to be used in determining my claim for compensation.
Name ……Date …….. Signature ……

C. EMPLOYEE'S REPRESENTATIVE CONSENT (IN CASE OF DEATH)

I, ……., wilfully agree that the medical information of the late……..…….contained herein to be used in determining a claim for compensation.
Name ……. Relationship with the deceased ……
Signature ……Date ……...

D. PARTICULARS OF A HEALTH CARE PROVIDER

Name of health care provider……...
Contact address……...……
Tel ……Fax…….WCF accreditation No. (if available) ……..

E. EMPLOYEE'S PARTICULARS

First Name…….. Middle Name ……. Last Name …….
Employee's code No. ……National ID No……..…… Employee's ID No ……..
Date of birth ……Sex……Marital status……...
Contact address……... Street/Village …….. District……
Region……..……..
Name of employer…….

F. INITIAL CONSULTATION PARTICULARS

i. Date of consultation…….
ii. General condition of the employee at the first consultation ……...
……
……
……
iii. For the case of accident, professional description of the injury (nature, pattern, structures involved, severity)
……
……
……
iv. For the case of occupational disease, professional description of the initial symptoms and signs presented by the employee
……
……
……
……
v. Summary of medical history of any medical condition pre-existed at the time of occurrence of an occupational accident or disease…….....

……...
……...

G. DETAILS OF SERVICES RENDERED

(a) Hospitalisation (fill appropriately)

S/No	Reasons for hospitalisation	Number of days
1.	Critical care	
2.	Observation	
3.	Surgery	
4.	Requirement of investigation procedure	
5.	Others	

(b) Medical investigation (s)

S/No.	Investigation	Reason (s) of investigation (mark √ where appropriate)				
		Diagnosis	Severity assessment	Prognosis	Surgery	Impairment assessment
1.						
2.						
3.						
4.						
5.						
6.						

(c) Medical follow up

S/No.	Clinic attended	Medical practitioner (name and qualification)	No. of days
1.	General outpatient		
2.	Medical specialist		
3.	Orthopedic and traumatology		
4.	General surgical		
5.	Pulmonary		
6.	Ophthalmology		
7.	Ear, Nose and Throat (ENT)		
8.	Others		

(d) Surgery

Date of surgery	Type	Reason (s)	Anaesthesia	Surgeon's name and qualification

(e) Current state of employee (patient) (Mark (√) in the appropriate box)

Fully recovered (Immediately resumed duties)	**Partially recovered** (Needs time to recuperate and resume duties) **Go to table (i) below**	**Need medical follow up** (Outcome not yet fully decided)	**Recovered with permanent loss of body part/function** (Specify part (s) and function (s) lost) **Go to table (ii) below**	**Referred** (Reasons of referral and expected benefits) **Go to (iii) below**	**Death** (Cause of death)

(i) Partially recovered (fill the table below)

Management	Reason(s)	No. of days
Complete day off		
Light duties		

(ii) For permanent loss of body part (s) or function (s) (complete table below)

Body part or function(s) lost	Manner of loss	Functions impaired	Impact of impairment	Rehabilitation recommended
Example: Distal third of left lower limb	Amputation after severe injury	Cannot walk freely unless supported	Footballer lower limb lost- can no longer play football	Artificial left lower limb

(iii) Referral Particulars

Date of referral	Referred to	Reason (s) for referral (mark (√) appropriately)			Expected benefits
		Investigation	Expertise	Patient demand	

H. FINAL DIAGNOSIS

i. What is the final diagnosis…….....
……...
……...
.....

ii. Supporting findings (attach relevant document…….
……..
……..
……...
……...

iii. Why is it occupational?
……
……
……
……

i. Medical practitioner's opinions and recommendations
……
……
……
……

ii. For death caused by occupational accident or disease
Date of death ……...
Professional description as to the cause of death
……..……..
……
……
……

DECLARATION

I, ……., declare that what I have stated herein above is true to the best of my knowledge.

Name…….Designation……Reg No……
Date……Signature……..……

Official stamp