INDUSTRIAL COMMISSION OF ARIZONA

WORKER'S & PHYSICIAN'S REPORT OF INJURY

INJURED WORKER'S RIGHT TO CHOOSE DOCTOR

IMMEDIATELY UPON COMPLETION PLEASE MAIL COPIES AS SHOWN BELOW

An employer who is not self-insured can direct you to a doctor of their choice for ONE visit. After the **ONE** visit, you may report to a doctor of your choice. **REMEMBER:** If you make a **SECOND** visit to the employer's doctor, you have established that doctor as your treating doctor. If your employer is self-insured, you may not be allowed to change doctors. **SEE INFORMATION SHEET ATTACHED TO THIS FORM FOR FURTHER INSTRUCTIONS.**

WORKER'S REPORT

NAME OF INJURED WORKER
LAST NAME FIRST M.I.

SOCIAL SECURITY NO.

PHONE NO.

ICA USE ONLY

INJURY CODE: _____

1.

2. ADDRESS CITY STATE ZIP

3. DATE OF BIRTH 4. SEX: MALE ○ FEMALE ○

5. SINGLE ○ WIDOWED ○ DIVORCED ○ MARRIED ○ IF SO, IS SPOUSE EMPLOYED YES ○ NO ○

6. OCCUPATION WHEN INJURED DATE OF INJURY TIME OF INJURY

7. EMPLOYER SUPERVISOR PHONE NO.

8. OFFICE ADDRESS CITY STATE ZIP

9. EMPLOYER'S INSURANCE CARRIER POLICY NO.

10. MAILING ADDRESS

11. DESCRIBE **WHERE** AND **HOW** ACCIDENT OR CAUSE OF DISABILITY OCCURRED (INCLUDING LOCATION AND/OR DEPARTMENT)

BY THIS INSTRUMENT I MAKE APPLICATION FOR ALL BENEFITS TO WHICH I MAY BE ENTITLED UNDER THE LAW AND I DO HEREBY CERTIFY, WITH FULL KNOWLEDGE THAT IT IS A CRIME TO MAKE WILLFUL, FALSE STATEMENTS TO OBTAIN COMPENSATION, THAT ALL OF MY STATEMENTS ON THIS FORM ARE TRUE, ACCURATE AND COMPLETE. I UNDERSTAND I MUST FOLLOW THE INSTRUCTIONS OF MY DOCTOR AND MUST HAVE WRITTEN APPROVAL FROM THE INDUSTRIAL COMMISSION TO LEAVE THE STATE OF ARIZONA OR MY LOCALITY FOR MORE THAN 14 DAYS, FAILURE TO DO SO MAY CAUSE FORFEITURE OF COMPENSATION BENEFITS.

WORKER EMAIL ADDRESS DATE OF SIGNING AT CITY STATE

EMPLOYER EMAIL ADDRESS

IMPORTANT: INJURED WORKER'S SIGNATURE REQUIRED HERE **X** _____

PHYSICIAN'S INITIAL REPORT

12. DATE FIRST TREATMENT HOUR 13. LOCATION: HOSPITAL ○ OFFICE ○ OTHER ○

14. DATE WORKING DISABILITY BEGAN 15. WHO ENGAGED YOUR SERVICES? PATIENT ○ EMPLOYER ○ OTHER ○

16. WAS PATIENT TREATED BY ANYONE ELSE? YES ○ NO ○ IF YES, BY WHOM?

17. COMPLAINTS AND PHYSICAL FINDINGS IN DETAIL:

18. ICD- CODE : DIAGNOSIS:

19. DESCRIBE ANY PRE-EXISTING IMPAIRMENT OR DISEASE AFFECTING PRESENT CONDITION

20. PATIENT IS RIGHT ○ LEFT ○ HANDED

21. DESCRIBE TREATMENT GIVEN BY YOU:

22. WERE X-RAYS TAKEN? YES ○ NO ○ IF YES, BY WHOM? WHEN

23. WAS LABORATORY WORK DONE? YES ○ NO ○ IF YES, BY WHOM WHEN

24. X-RAY DIAGNOSIS (ATTACH ROENTGENOLOGICAL REPORT FORM)

25. WAS PATIENT HOSPITALIZED? YES ○ NO ○ IF YES, WHERE

26. DATE OF ADMISSION TO HOSPITAL 27. DATE OF DISCHARGE

28. IS FURTHER TREATMENT NEEDED? YES ○ NO ○ IF YES, FOR HOW LONG

29. IS PATIENT, AS A RESULT OF CONDITIONS DUE TO THIS ACCIDENT: (A) SUBJECT TO SUSTAIN A PERMANENT DEFECT OF IMPAIRMENT? YES ○ NO ○

(B) ABLE TO DO THE SAME TYPE OF WORK HE PERFORMED AT TIME OF INJURY? YES ○ NO ○ IF YES, DATE ABLE IF NOT, ANTICIPATED DATE

(C) ABLE TO DO A LIGHTER OR DIFFERENT TYPE OF WORK THAN PERFORMED AT TIME OF INJURY? YES ○ NO ○ IF YES, DATE ABLE

IF NOT, ANTICIPATED DATE ABLE

30. REMARKS:

NAME OF PHYSICIAN BILLING CODE NO.

ADDRESS ZIP PHONE

IRS. NO. PROFESSIONAL CORP? YES ○ NO ○

DATE OF THIS REPORT PHYSICIAN'S SIGNATURE REQUIRED HERE **X** _____

THIS FORM APPROVED BY THE INDUSTRIAL COMMISSION OF ARIZONA FOR CARRIER USE.

Information for Completing Worker's and Physician's Report of Injury

Detach this Sheet and Give to Patient

Answer all questions in full. Use ball point pen or typewriter.

Injured worker:
This is the claim that will be used to notify the Industrial Commission, your employer and your employer's insurance carrier of your claim for workers' compensation benefits.

This form must be completed in full and all questions answered. Your claim for benefits cannot be promptly processed without the following:

Full Name of Your Employer
Employer's Complete Address
Employer's Phone Number
Your Exact Date of Injury (Month-Day-Year)
Your Signature
Social Security Number *

Right to choose physician:
When an injury occurs an employer has the right to have an injured worker seen by a doctor of the employer's choice one time. **(If you return to that physician a second time, that physician would become your attending physician).** After the one visit to the employer's designated physician you may report to a physician of your choice. **Exception:** if your employer is self-insured you must follow the self-insured employer's directed care program. To determine if your employer is self-insured, you may contact the Industrial Commission of Arizona Claims Division at (602) 542-4661.

If you wish to change physicians after your initial selection, please contact the Industrial Commission of Arizona at (602) 542-4661

Medical provider:
The worker's and physician's report of injury must be filed within eight (8) days after first rendering treatment. Mail the original to the Industrial Commission of Arizona at P.O. Box 19070, Phoenix, AZ 85005 and one (1) copy to the employer and one (1) copy to the employer's insurance carrier.

Form available in alternative format:
The Industrial Commission complies with the Americans with Disabilities Act of 1990.
If you need this document in alternative format, contact Claims at (602) 542-4661.

* The mandatory requirement that the social security number be included in forms filed with the Claims Division or Special Fund Division of the Industrial Commission of Arizona is permitted by Section 7 (a)(2)(b) of the Federal Privacy Act of 1974, because the Commission's forms, prescribed under the Commission's rules in existence prior to January 1, 1975, required disclosure of the social security number. The number is used as a means of identifying all the various records in the Claims Division or Special Fund pertaining to an individual. The use of social security numbers is made necessary because of the large number of persons who have similar names and birth dates, and whose identities can only be distinguished by the social security number.