Worker's Compensation Form No. 2

STANDARD FORM FOR
SURGEON'S REPORT

COMMISSIONER OF LABOR
VIRGIN ISLANDS OF THE UNITED STATES

Commission's Number	**File:**
	Carrier:
	Employer:
Carrier's File No.	**(The spaces above not to be filled in by Employer)**

The Patient

1. Name of Injured Person: _____ Age _____ Sex _____
2. Address: No. & St. _____ City or Town _____ Virgin Islands of USA
3. Name & Address of Employer: _____

The Accident

4. Date of Accident: _____ Hour _____ AM PM (Circle One) Date Disability Began _____
5. State in patient's own words where and how accident occurred _____

The Injury

6. Give accurate description of nature and extend of injury and state your objective findings: _____

7. Will the injury result in (a) Permanent defect? _____ If so, what? _____
   (b) Facial or head disfigurement? _____
8. Is accident referred to the only cause of patient's condition? _____ If not, state contributing causes _____

9. Is patient suffering from any disease of the heart, lungs, brains, kidneys, blood vascular system or any other disabling condition due to this accident? _____
   Give Particulars: _____
10. Has patient any physical impairment due to previous accident or disease? _____ Give Particulars: _____
11. Has normal recovery been delayed for any reason? _____ Give Particulars: _____
11b. Name and type of medication Prescribed for this injury: _____

12. Date of your treatment: _____ Who engaged your services? _____
13. Describe treatment given by you: _____
14. Were X-rays taken? _____ If so, by whom? _____ (Name and Address) When? _____
15. X-rays diagnosis _____
16. Was patient treated by anyone else? _____ If so, by whom? _____ (Name and Address) When? _____
17. Was patient hospitalized? _____ Name and Address of Hospital: _____
18. Date of admission to hospital: Date of Discharge? Is further treatment needed? For How Long?

Disability

19. Patient was/will be able to resume light duty on: _____
20. Patient was/will be able to resume work on: _____
21. If death ensued, give date: _____

REMARKS: (Give information of value not included above)

Signature

I am duly licensed physician in the State of: _____

I graduated from _____ Medical School In _____ Year _____

Date of this Report: _____ Signed: _____

This Report must be signed personally by Physician. Address: