WORKERS' COMPENSATION TREATMENT PLAN

THIS SECTION TO BE COMPLETED BY THE EMPLOYER

Patient Information	Employer Information	Medical Provider Information
Name	Name	Name
Address	Address	Address
Phone	Phone	Phone
Claim number		Visit date
Date of birth		
Date of injury		
Job title		

THIS SECTION TO BE COMPLETED BY THE TREATING PHYSICIAN

Assessment		
Diagnosis/ICS9 code		
Treatment rendered	X-rays of	
	Meds (prescription)	
	Meds (nonprescription)	
Treatment plan	Scheduled appointment/referrals	
	To specialist	
	Date	Time
	Return appointment scheduled	
	Date	Time
Return-to-work disposition		
❑ Restricted duty	From date	To date
List restrictions		
❑ Full duty, **without** restrictions	Beginning date	❑ Pending reevaluation
I understand that it is my responsibility to supply a copy of this form to Summit via fax withing 24 hours of this patient's visit.		
Physician's signature		Date

THIS SECTION TO BE COMPLETED BY THE PATIENT

I hereby authorize the treating physician to disclose any information regarding this incident to Summit. By signing below, I also release the physician from any liability arising from such disclosure.

Patient's signature Date

This form should be faxed to 678-989-5858 by the physician's office within 24 hours of the patient's visit.

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