South Carolina Workers' Compensation Commission
1333 Main Street, Suite 500 • Post Office Box 1715
Columbia, South Carolina 29202-1715
(803) 737-5675
www.wcc.sc.gov

Physician's Statement

Claimant's Name: _____ Employer's Name: _____

Physician's Name: _____ Insurance Carrier: _____

Practice/Clinic: _____ SCWCC File No: _____

Preparer's Name: _____ Phone: _____

The undersigned physician has been authorized to evaluate or treat this Claimant for his or her injury by accident pursuant to**§§42-15-60, 42-15-80, 42-1-172, or 42-11-10.**

Date of injury or illness:_____

Date of first office visit: _____ Date of last visit: _____

Diagnosis or nature of injury or illness: _____

Body part(s) injured: _____ Body part(s) affected: _____

Date of **Maximum Medical Improvement**: _____

Based on the AMA Guidelines, _____Edition, the Claimant has sustained the following medical impairment as a result of the work related injury:
_____% medical impairment to the _____ (injured body part)

If there is causally-related medical impairment to other body parts as a result of the work related injury, please indicate the impairment below.
____% medical impairment to the _____ (additional body part injured or affected)
____% medical impairment to the _____ (additional body part injured or affected)

☐ The Claimant is **able to return to work** without restriction.

☐ The Claimant is **able** to return to work **with the following restrictions:**

☐ The Claimant is **unable to return to work** at the employment in which the patient was injured.

☐ The Claimant **possesses retained hardware** causally related to this injury.

As of the date you last saw the patient, please provide your opinion to a reasonable degree of medical certainty as to whether the patient will most probably need future medical care related to his or her work related injury or illness. "**Most probably" means more likely than not or with greater than 50% probability**.

☐ The patient **most probably will not** (50% or less probability) need future medical care related to his or her work related injury or illness based on a reasonable degree of medical certainty.

☐ The patient **most probably will** (greater than 50% probability) need future medical care and treatment related to his or her work related injury or illness and that future medical care and treatment including medication is as follows:

*An indication or statement that future medical care "may be necessary" or "might be necessary" is not sufficient and will require further clarification.

_____
Treating or Evaluating Physician

_____
Date