|  |  |  |
| --- | --- | --- |
| South Carolina Workers’ Compensation Commission1333 Main Street, Suite 500 ● Post Office Box 1715Columbia, South Carolina 29202-1715(803) 737-5675www.wcc.sc.gov | SCSealBWjpg | **Physician’s Statement** |
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|  |  |
| --- | --- |
| Claimant's Name: |  |
|  |  |
| Physician’s Name: |  |
|  |
| Practice/Clinic:  |  |

|  |  |
| --- | --- |
| Preparer’s Name:  |  |
|  |  |

 |

|  |
| --- |
|  |
| Employer’s Name:  |  |
| Insurance Carrier:  |  |
|  |
| SCWCC File No:  |  |
| Phone: |  |

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The undersigned physician has been authorized to evaluate or treat this Claimant for his or her work injury or illness pursuant to *South Carolina Code Sections
42-*-15-60, 42-15-80, 42-1-172, or 42-11-10.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Date of injury:**  |  | Date of first office visit:  |  | Date of last office visit: |  |

**The medical opinions below are stated to a reasonable degree of medical certainty.**

|  |  |
| --- | --- |
| Diagnosis or nature of injury or illness:  |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Body part(s) injured:  |  | Body part(s) affected: |  |

|  |  |
| --- | --- |
| Date of **maximum medical improvement**: |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Has the Claimant sustained **permanent physical impairment** as a result of the work injury?  |  | Yes |  | No |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| If so, the permanent physical impairment is:  |  | % medical impairment to the |  | (injured body part). |

If there is a permanent physical impairment to other body part(s) as a result of the work injury, please indicate below:

|  |  |  |  |
| --- | --- | --- | --- |
|  | % medical impairment to the  |  | (additional body part injured or affected). |

The impairment rating(s) above are based upon the following:

|  |  |  |  |
| --- | --- | --- | --- |
|  | The AMA’s *Guides to the Evaluation of Permanent Impairment* |  | Edition; or |
|  | Other medical treatise: |  | or |
|  | Other: |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Does the Claimant have **permanent physical limitations** as a result of the injury? |  | Yes |  | No |

|  |  |
| --- | --- |
| If so, the permanent physical limitations are: |  |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Does the Claimant **possess retained hardware** as a result of the injury? |  | Yes |  | No |

|  |  |
| --- | --- |
| If so, the retained hardware is: |  |

|  |
| --- |
| Is there **medical, surgical, hospital or other treatment** that the Claimant needs as a result of the injury for an additional time that will tend |
| to lessen the period of disability or maintain the current level of function: |  | Yes |  | No |

If so, the medical care and treatment that is needed is/are:

|  |
| --- |
|  |

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

**I certify that I am a physician or other licensed healthcare provider, I have personally read and prepared this document, and the opinions reflected above are mine.**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |  |
| --- | --- |
| **Treating or Evaluating Physician**  | **Date** |
|

|  |  |  |
| --- | --- | --- |
| WCC Form #14B12/2016 | 14B | Physician’s Statement |

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