South Carolina Workers' Compensation Commission
1333 Main Street, Suite 500 • Post Office Box 1715
Columbia, South Carolina 29202-1715
(803) 737-5723
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 by the Employer/Carrier to treat this Claimant for his or her injury by accident pursuant to**§§42-15-60, 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**, the claimant has sustained a _____**% medical impairment** to _____ injured body part(s) and a _____**% medical impairment** to_____ other affected body part(s).

☐ 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 his or her current employment.

As of the date I last saw this patient, it is **my professional medical opinion** the claimant:

☐ **will not** need future medical care related to his or her work related injury or illness based on a reasonable degree of medical certainty (more likely than not).

☐ **will** need future medical care and treatment related to his or her work related injury or illness based on a reasonable degree of medical certainty (more likely than not) and that medical care and treatment including medication is as follows:

_____

_____

_____

_____ _____

Treating Physician **Date**