Reset Form

University of South Carolina
Workers' Compensation
Physician's Report

General Information

Name of Claimant: _____
Last, First, M.I.

Social Security # _____

Did this injury arise out of the claimant's employment?
☐ Yes ☐ No ☐ Unknown

Date of First Treatment: _____

Diagnosis:

Work Status:

☐ May return to work: ☐ Full Duty ☐ Restricted Duty

☐ May not return to work until _____
Date

Restrictions:

☐ May not lift greater than _____ lbs.

☐ Not climbing stairs or ladders

☐ Other _____

☐ The employee has been advised to follow these restrictions for _____ days and/or _____ weeks

Date of Next Visit:

☐ Return appointment is scheduled for _____
Date

☐ Patient referred to _____

Name of Physician:

Signed: _____ Date _____

Address: _____

_____

A copy to each of the following: Benefits; State Accident Fund; TSHC; Department/Employee.