Form 043

ATTENDING PHYSICIAN'S STATEMENT

This Form must accompany Form 044.

TO THE INJURED WORKER: Prior to mailing this form to the last physician who treated you in the state of Utah, please complete the following:

Your Complete Name: _____

Your Complete Current Mailing Address: _____

_____

Date of Injury: _____ Social Security Number: _____

Employer: _____ Insurance Carrier: _____

TO THE PHYSICIAN: Please complete this form and send back to the injured worker AS SOON AS POSSIBLE. The injured worker will need to send this form plus Form 044 – Employee's Intent to Leave State to the Labor Commission, Division of Industrial Accidents, 160 East 300 South, 3rd Floor, P.O. Box 146610, Salt Lake City, UT 84114-6610, (801) 530-6800.

1. Condition of Employee when last examined: _____

   Date of Last Examination: _____

2. If Applicant is not released to return to work at time of last examination, please provide your best professional opinion as to the following:

   a. Estimated date of stabilization or return to work: _____

   b. Additional medical treatment required: _____

   c. Probability and extent of permanent partial impairment: _____

3. If attending physician is responsible for referring injured employee to another physician, clinic, or hospital, please indicate to which doctor, clinic, or hospital and provide the address thereof. Please give a brief explanation of your referral.

_____ _____

Printed Name of Attending Physician Signature of Attending Physician

_____

Number, Street and Suite #

_____

City/State/Zip

Date of this Report: _____

UTAH LABOR COMMISSION
Industrial Accidents Division

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