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 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**