

PHYSICIANS REPORT

Patient Name

Injury date *(as reported to you by the patient)*

Date the patient is released to return to work: Not yet released

Diagnosis based on Physician's findings (attach copy of initial history, if available):

In your opinion, was the injury (physical or emotional) caused, aggravated, or accelerated by the victimization? Yes No.

In your opinion, would the patient's physical and/or emotional condition impair him/her from working? Yes No.

What, if any, permanent disabilities have resulted from the victimization?

Additional Information you would like to bring to the attention of the Crime Victims Compensation Board:

Thank you for your prompt response to these questions. Your assistance is vital to the Victims Compensation Program's ability to assist this patient with the payment of medical expenses and loss of wages as a result of the criminal incident.

Date signed _____

Physician's Signature

Federal Tax I.D. #

Physicians' Name *(Please Print)*

Telephone #

Address

City, State, Zip Code

Please Return Form To: