



**PHYSICIAN'S REPORT**  
State Form 2118 (R4 / 8-11)

**INDIANA WORKER'S COMPENSATION BOARD**  
402 West Washington Street, Room W196  
Indianapolis, IN 46204-2753  
Telephone: (317) 232-3808

\* This agency is requesting disclosure of your Social Security number in order to pursue its statutory responsibilities. Disclosure is voluntary and you will not be penalized for refusal.

**INSTRUCTIONS:** Page 1 of this form is for the examination; page 2 is for Permanent Partial Impairment (PPI).

PATIENT INFORMATION			
Social Security number *	Name of injured employee	Age	Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
Address (number and street, city, state, and ZIP code)			
Name of employer		Date of this report (month, day, year)	
Address (number and street, city, state, and ZIP code)			

ACCIDENT INFORMATION	
Date of injury (month, day, year)	Time of injury / illness / exposure <input type="checkbox"/> AM <input type="checkbox"/> PM
Briefly describe accident / exposure as reported by worker ----- -----	

PHYSICIAN'S FINDINGS - Please attach causation.	
State objective findings of injury / illness / exposure -----	
Ability to work <input type="checkbox"/> Unable to work beginning ____ until ____. <input type="checkbox"/> Able to work with restrictions beginning ____ until ____. <input type="checkbox"/> Able to work full duty effective ____.	
Is this the only cause of patient's condition? (If No, state contributing causes) <input type="checkbox"/> Yes <input type="checkbox"/> No -----	
In your opinion, are the worker's current symptoms a result of the injury described above? <input type="checkbox"/> Yes <input type="checkbox"/> No	If no, did the injury aggravate, exacerbate, or accelerate a pre-existing condition? <input type="checkbox"/> Yes <input type="checkbox"/> No
Has normal recovery been delayed for any reason? (If Yes, please explain) <input type="checkbox"/> Yes <input type="checkbox"/> No -----	
Medical status <input type="checkbox"/> Maximum Medical Improvement (MMI) <input type="checkbox"/> Disabled	If MMI, date achieved (month, day, year)
If disabled, type: <input type="checkbox"/> Partial but temporary <input type="checkbox"/> Totally but temporary <input type="checkbox"/> Totally and permanent	

ATTENDING PHYSICIAN TREATMENT			
Date of your first treatment (month, day, year)	Who engaged your services?		
Describe treatment given or ordered by you ----- -----			
Was patient treated by a previous physician? (If Yes, by whom, give name) <input type="checkbox"/> Yes <input type="checkbox"/> No			Date treated (month, day, year)
Was patient hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No	Name of hospital	Date of admission (month, day, year)	Date of discharge (month, day, year)
Is further treatment needed? (If Yes, please explain) <input type="checkbox"/> Yes <input type="checkbox"/> No			

(Check one)  
 Patient  was  will be able to resume regular work on \_\_\_\_\_ (month, day, year).

(Check one)  
 Patient  was  will be able to resume light duty work on \_\_\_\_\_ (month, day, year). Please explain any restrictions below.

If there is permanent impairment as a result of this injury / illness / exposure, please give body part affected, degree of impairment and other pertinent information. (If there is an amputation to the hand or the foot, please indicate the point of amputation on one of the diagrams below.)

<input type="checkbox"/> Thumb _____%	<input type="checkbox"/> Toe, Great _____%	<input type="checkbox"/> Hand below elbow _____%	<input type="checkbox"/> Loss of vision to <1/10 normal _____%
<input type="checkbox"/> Finger 1 _____%	<input type="checkbox"/> Toe 2 _____%	<input type="checkbox"/> Arm above elbow _____%	<input type="checkbox"/> Loss of eye _____%
<input type="checkbox"/> Finger 2 _____%	<input type="checkbox"/> Toe 3 _____%	<input type="checkbox"/> Foot below knee _____%	<input type="checkbox"/> Hearing, left or right _____%
<input type="checkbox"/> Finger 3 _____%	<input type="checkbox"/> Toe 4 _____%	<input type="checkbox"/> Leg below knee _____%	<input type="checkbox"/> Hearing, both ears _____%
<input type="checkbox"/> Finger 4 _____%	<input type="checkbox"/> Toe 5 _____%	<input type="checkbox"/> Spine _____%	<input type="checkbox"/> Testicle loss, one _____%
			<input type="checkbox"/> Testicle loss, both _____%

To calculate the PPI amount, multiply the degree value by the percentage of loss. Multiply the result by the appropriate dollar amount for the date of injury. If an amputation, double the value.

Remarks: (Use this section for an independent medical examination report or give any information of value not included above i.e. history, prognosis, or work restrictions of the patient.)

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Is this report submitted as an independent medical examination? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is further treatment necessary? (If necessary, please explain response in the remarks section above. Supplemental reports may be submitted with this form.) <input type="checkbox"/> Yes <input type="checkbox"/> No
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Signature of physician \_\_\_\_\_ Date (month, day, year) \_\_\_\_\_

Printed name of physician \_\_\_\_\_ Telephone number ( ) \_\_\_\_\_

Address of physician (number and street, city, state, and ZIP code) \_\_\_\_\_

PPI rating provided according to \_\_\_\_\_ Ed. AMA guidelines.

