VML INSURANCE PROGRAMS
Virginia's Local Government Specialists®

Work Comp Medical First Report

1. **To be completed by the treating physician - Please send completed forms to VML Insurance Programs - fax 800-273-4865**
2. **Please provide the patient with a copy of the completed form.**
3. **Patient, provide your supervisor with a copy of this form after treating.**

Patient's Name: _____

Patient's Address: _____

Name of Employer: _____

Date of Accident or Illness: ____/____/____

Patients account of How Injury or Exposure Occurred: _____

_____

Name of Medical Facility: _____

Date of Visit: ____/____/____ Arrival Time: _____ AM/PM Departure Time: _____ AM/PM

Diagnosis: _____

New Injury/Illness ☐ Existing Condition ☐

* *

Recommended Work Status:

A) May return to full duty beginning: ____/____/____

B) May return to modified duty beginning: ____/____/____

- Recommendation based on:
  - _____personal review of functional job description
  - _____verbal description of job by employee/patient
  - _____verbal description of job by employer representative
  - _____other (describe:_____)
- The employee/patient is **medically able** to do the following activities:

  _____

  _____
- Does condition preclude travel to and from work ☐ Yes ☐ No
- Does condition preclude being at work ☐ Yes ☐ No
- Anticipate return to full duty beginning: ____/____/____

C) Unable to work at this time ☐

- Anticipate return to modified duty beginning: ____/____/____
- Anticipate return to full duty beginning: ____/____/____

Physician's Comments (Please note any contributing factors, prior injuries and pre-existing conditions):

_____

_____

Follow-Up Appointment with: _____ Date: ____/____/____ Time: __ _____ AM/PM

To ensure payment, any follow-up care must be authorized by VML Insurance Programs

Physician/Clinician Name (please print): _____ Phone #_____

Physician/Clinician Signature: _____