

Attending Physician's Report

Virginia Workers' Compensation Commission
 1000 DMV Drive Richmond VA 23220
 See instructions on the reverse of this form.

The boxes to the right are for the use of the insurer	Reserved	VWC file number
	Insurer code	Insurer location
	Insurer claim number	

Employee			
1. Patient's name		2. Phone number	
3. Address		4. Date of birth	5. Sex <input type="checkbox"/> Male <input type="checkbox"/> Female
		6. Social security number	
Background Information			
7. Name of employer		8. Address of employer	
9. Date of injury or illness			
10. Patient's account of how injury or exposure to occupational disease occurred			
11. Date of first visit		12. Date of discharge	13. Person authorizing treatment
Findings and Diagnosis			
14. Findings upon examination, including results of x-rays, laboratory studies, etc. Please note any prior injuries and pre-existing conditions. Provide additional comments on the reverse side of this form.			
15. Diagnosis			16. Is diagnosed condition due to the occurrence described by the patient? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown
17. Nature of treatment			18. Dates of your treatment
19. Provide names and addresses of other health care providers to whom patient was referred			
20. Was there any fracture or amputation? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		If yes	21. Please describe
22. Was there disability for work? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		If yes	23. Date disability began
			24. Date able to return to light work
			25. Date able to return to regular work
26. Will there be any permanent defect or disfigurement? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown		If yes	27. Please describe
			28. Has patient reached maximum medical improvement? <input type="checkbox"/> Yes <input type="checkbox"/> No
Attending Physician			
29. Name of attending physician		30. Address	
31. Date of this report			
I certify that I personally examined and treated this patient			
		Signature _____	M.D.

FILING INSTRUCTIONS
(Instructions Updated 09/01/07)

Attending Physician's Report
VWC Form 6

The treating physician completes this form and the report provides specific medical information including date of accident, diagnosis, prognosis, the disability period(s), and the extent of any permanent disability.

Forms: Additional copies of this form are available without cost by writing to the Commission. Address your inquiry to "Forms" at the listed Virginia Workers' Compensation Commission address. The form is also available on the Commission's Website, at www.workcomp.virginia.gov. Please note that any alternate versions of the form you develop yourself require prior approval by the Commission.

For questions or assistance with completing the form, please contact the Awards Unit using the Commission's Toll-free number (1-877) 664-2566 or visit our Website, at www.workcomp.virginia.gov.