pinnacle
MEDICAL GROUP, INC.

DOCTOR'S FIRST REPORT OF WORK INJURY

Within 5 days of your initial examination, for every occupational injury or illness, send this report to **insurer or employer (only if self-insured).** Failure to file a timely doctor's report may result in assessment of a civil penalty. **In the case of diagnosed or suspected pesticide poisoning,** send one copy of this report directly to the Division of Labor Statistics and Research, P.O. Box 603, San Francisco, CA 94101; and notify your local health officer by telephone within 24 hours and by sending a copy of this report within seven days. For a supply of this form, please call (415) 557-1924.

								PLEASE DO NOT USE THIS COLUMN
1. **INSURER NAME AND ADDRESS**								
2. **EMPLOYER NAME**								Case No.
3. Address:	No. and Street		City			Zip		Industry
4. Nature of business (e.g., food manufacturing, building construction, retailer of women's clothes)								County
5. **PATIENT NAME** (First name, middle initial, last name)			6. Sex	7. Date of Birth	Mo.	Day	Yr.	Age
8. Address:	No. and Street	City	Zip	9. Telephone number				Hazard
10. Occupation (Specific job title)				11. Social Security Number				Disease
12. Injured at:	No. and Street		City	County				Hospitalization
13. Date and time of injury or onset of illness	Mo. Day Yr.		Time	14. Date last worked	Mo.	Day	Yr.	Occupation
15. Date and time of injury examination or treatment	Mo. Day Yr.		Time	16. Have you (or your office) previously treated patient?				Return Date Code

Patient please complete this portion, if able to do so. Otherwise, doctor please complete immediately. Inability or failure of a patient to complete this portion shall not affect his/her rights to workers' compensation under the California Labor Code.

17. **DESCRIBE HOW THE ACCIDENT OR EXPOSURE HAPPENED** (Give specific object, machinery or chemical. Use reverse side if more space is required.)

18. **SUBJECTIVE COMPLAINTS** (Describe fully. Use reverse side if more space is required.)

19. **OBJECTIVE FINDINGS** (Use reverse side if more space is required.)
A. Physical examination

B. X-ray and laboratory results (State if none or pending.)

20. **DIAGNOSIS** (If occupational illness, specify etiologic agent and duration of exposure.) Chemical or toxic compounds involved?

21. Are your findings and diagnosis consistent with patient's account of injury or onset of illness?
If "no", please explain.

22. Is there any other current condition that will impede or delay patient's recovery?
If "yes", please explain.

23. **TREATMENT RENDERED** (Use reverse side if more space is required.)

If further treatment required, specify treatment. Estimated duration

24. If hospitalized as inpatient, give hospital name and location. Date admitted Mo. Day Yr. Estimated stay

25. **WORK STATUS** Is patient able to perform usual work?
If "no", patient can return to: Mo. Day Yr.

Regular work ____________
Modified work ____________ Specify restrictions ____________

Doctor's Signature ____________ Date ____________ CA License Number ____________
Doctor Name and Degree (Please Type) ____________ IRS Number ____________
Address ____________ Telephone Number ( )

PMG-054 (9/09)