Request for Examination and/or Treatment

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U.S. Department of Labor
Employment Standards Administration
Office of Workers' Compensation Programs

Part A - Authorization

OMB No. 1215-0066

Instructions to Employer. This page of the form must be completed in full, and authorizes a physician of the **employee's choice** (*See item 2 below) to examine and/or treat an employee, covered by the Federal Workers' Compensation Act marked in the box at right, for accidental injury, illness or disease arising out of and in the course of employment.

Mark either box A or B in item 7. The original and at least two copies of this form are to be given to the physician. The physician is to complete the medical report and the initial bill on the reverse, sending within ten days the original of the report to the District Director and copies to the insurance company or employer named in item 13. Subsequent and regular follow-up reports should be submitted by the physician on Form LS-204 and/or in narrative reports, whenever requested.

An employee may not select a physician who is currently not authorized by the Department of Labor to provide medical care under the Act.

1. This Authorization is for examination and/or treatment under the Workers' Compensation Act marked below:

- A ☐ Longshore and Harbor Workers' Compensation Act
- B ☐ Defense Base Act
- C ☐ Nonappropriated Fund Instrumentalities Act
- D ☐ Outer Continental Shelf Lands Act

2. Name and address of physician or medical facility authorized to provide medical service

* (The term "physician" includes doctors of medicine (MD), surgeons, podiatrists, dentists, clinical psychologists, optometrists, osteopathic practitioners, and chiropractors. Payment for chiropractic services is limited to charges for physical examinations, related laboratory tests, x-rays to diagnose a subluxation of the spine, and treatment consisting of manipulation of the spine to correct a subluxation demonstrated by x-ray. See 20 CFR 702.404)

name: line 1: line 2: city: state: zip: country:

3. Employee's Name First Name M.I. Last Name

4. Date of Injury (mm/dd/yyyy)

5. Occupation

6. How accident or illness occurred

7. You are authorized to provide medical services to the employee as follows:

A ☐ If you believe the condition is related to the injury, or the employee's occupation, furnish office and/or hospital treatment as necessary for the effects of this injury.

B ☐ If you are in doubt as to whether the condition(s) found on examination is related to the injury, you are authorized to examine the employee, using indicated non-surgical diagnostic studies, and should promptly advise those listed in item 13 whether you believe the disability is due to the alleged injury. Pending further advice you may provide necessary conservative treatment.

You are requested to submit a written report of first treatment within 10 days to the District Director at the Office named in item 12 below (See back of this form for Instructions as to medical report and the submission of your charges).

8. Signature and title of authorizing official (Sign all copies)

name title

9. Name and address of employer ctry:

name: line 1: line 2: city: st: zip:

10. Telephone (Area code and local number)

11. Date authorized (mm/dd/yyyy)

12. Send one copy of your report to:

U.S. Department of Labor
Employment Standards Administration
Office of Workers' Compensation Programs

13. Name and address of insurance carrier or self-insured employer to whom bill and copy of report are to be sent

name: line 1: line 2: city: st: zip: country:

Public Burden Statement

The following statement is made in accordance with the Privacy Act of 1974 (5 USC 552a) and the Paperwork Reduction Act of 1995, as amended. The authority for requesting the following information is 20CFR 702.419. Use of this form is optional, however furnishing the information is required in order to obtain and/or retain benefits. According to the Paperwork Reduction Act of 1995, an agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 1215-0066. The time required to complete this information collection is estimated to average 65 minutes per response, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information, including suggestions for reducing this burden, to the U.S. Department of Labor, Division of Longshore and Harbor Workers' Compensation, Room C4315, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

DO NOT SEND THE COMPLETED FORM TO THIS OFFICE

Part B - Attending Physician's Report of Injury and Treatment

Instructions To Physician: This Initial report should be completed and submitted within 10 days. Mail the original to the District Director (see Item 12 for address), and a copy to the company listed In Item 13. Subsequent reports should be made regularly on form LS-204 and/or in narrative form while the employee is In your care. Please read item 7 on the front of this form. Your Social Security Number is voluntary and is used for identification purposes only.

14. What history of injury or disease did employee give you?

15. Is there any history or evidence of pre-existing injury, disease, or physical impairment?

☐ No ☐ Yes - Please describe

16. What are your findings (include results of x-rays, laboratory tests, etc.)?

17. What is your diagnosis?

18. Do you believe the condition found was caused or aggravated by the employment activity described? (Please explain your answer if there is doubt.)

☐ Yes ☐ No

19a. Did injury require hospitalization? ☐ No ☐ Yes - Complete b, c, d

b. Name of hospital

c. Date admitted (mm/dd/yyyy)

d. Date discharged

20. Is additional hospitalization required?

☐ Yes ☐ No

21. Surgery (If any, describe type)

22. Date surgery performed (mm/dd/yyyy)

23. What type of treatment did you provide other than hospitalization or surgery?

24. What permanent effects of the injury, if any, do you anticipate?

25. Date of first examination (mm/dd/yyyy)

26. Date(s) of treatment (mm/dd/yyyy)

27. Date of discharge from treatment (mm/dd/yyyy)

28. Period of disability (if termination date unknown - so indicate)

Total disability: From To

Partial disability: From To

29. Date employee able to resume work (mm/dd/yyyy)

To light work

To regular work

30. If employee is able to resume work, has he/she been advised? ☐ No ☐ Yes - Furnish date advised (mm/dd/yyyy)

31. If employee is able to resume only light work, indicate physical limitations and the type of work which can reasonably be performed with these limitations.

32. Remarks and recommendation for future care. if indicated.

33. Do you specialize? ☐ No ☐ Yes - State specialty

34. Signature and typed name of physician

First Name M.I. Last Name

35. Address

line1:

line2:

city: country:

st: zip:

36. Physician's social security number

37. Date of this report (mm/dd/yyyy)

38. Medical bill (Charges for your services may be presented in the space below or on your billhead stationery.)

Date or period of treatment	Services and supplies must be itemized	Qty. or No.	Unit price Cost	Unit price Per	Amount
				Total	