The North Carolina Family Doctor, PA * 1728 Fordham Blvd * 151 Rams Plaza * Chapel Hill, NC * 27514
(919) 968-1985 * FAX: (919) 942-0038

Chart Number: _____ - _____ WC

Today's Date: _____ UDS Required?: Yes No **(If yes, must have COC Form)**

Injured Employee: _____ SSN: _____

Date of Injury: _____ Nature of Injury: _____

Employer Name: _____ Phone: _____

Authorizing Party: _____ Fax: _____

E-Mail Address: _____

Insurance Company: _____ Phone: _____

Mailing Address: _____

Did employer submit Form 19 (First Report of Injury) to their Worker's Compensation Carrier?

Circle: NO YES* *(Claim Number: _____)

If NO, when and by whom will the Form 19 be submitted to the Worker's Compensation Carrier?

Date: _____ Name: _____

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Injured Employee's Name: _____

**DISPOSITION:**

_____ Patient may return to work without restrictions.

_____ Patient may return to work with the following restrictions: _____

_____

_____ Patient will be unable to work for _____ day(s).

_____ Patient requires referral to Specialist: _____

**DIAGNOSIS:** _____

**TREATMENT:** _____

_____

_____

Provider's Signature Date

☐ Copy Given To Patient ☐ Copy Faxed to Employer ☐ Copy Mailed to Employer ☐ Copy Emailed to Employer