



Worker's and Physician's Report for Workers' Compensation Claims

OPTIONAL WCD employer no.: Policy no.:

Note to Physician or Nurse Practitioner: Ask the worker to complete this form ONLY for the three filing reasons in the worker's section; do not have the worker complete or sign form if this is a progress report or palliative-care request.

Worker or physician section containing fields for worker's legal name, language preference, claim no., date of birth, employer at time of injury, occupation, and last date worked.

Worker section containing checkboxes for injury types (First report, Report of aggravation, Notice of change), reason for change, and signature lines for worker and physician.

Physician section containing checkboxes for injury types (First report, Change of attending physician, Progress report, Aggravation, Palliative care request) and a box for notes.

Physician section containing fields for treatment dates, hospitalization status, diagnosis, and work ability status.

Physician section containing a large notes area, symptoms, objective findings, and treatment details.

If you don't know the name and address of the insurer, call the Workers' Compensation Division's Employer Index (503) 947-7814, or visit on-line: www4.cbs.state.or.us/ex/wcd/cov/search/index.cfm

Physician's or nurse practitioner's signature Date

This form replaces and satisfies reporting requirements for Forms 827, 828, 829, 2215, and 2837. See Bulletin 292.

- Original and one copy to insurer
- Retain copy for your records
- Copy to worker immediately if initial claim, aggravation claim, or change of physician