# Attending Physicians Report

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

1. Patient's name Last       First       Middle       2. Date of lipury mo. day yr       3. OWCP File       OME Biol. 1215- Gradient's name Last         4. What history of injury (including disease) did patient give you?       6. Is there any history or injury (includie results of X-Rays, laboratory reports, etc.)       ICD-9 Code       ICD-9 Code         6. Is there any history or evidence of concurrent or pre-existing injury or disease or physical impairment?       ICD-9 Code       ICD-9 Code         7. What is your diagnosis?       ICD-9 Code       ICD-9 Code       ICD-9 Code         8. Do you believe the condition found was caused or aggravated by an employment activity? (Flease explain answer)       12. Additional Hopping/addition       ICD-9 Code         9. Dig laying magnet high-plain(action)?       10. Date of admission       11. Date of discharge       12. Additional Hopping/addition         13. What treatment did you provide?       10. Date of admission       11. Date of discharge from mo. day yr.       12. Additional Hopping/addition         14. Date of first examination mo. day yr.       15. Date(s) of freatment mo. day yr.       16. Date of discharge from mo. day yr.       10. Date of adminission mo. day yr.       10. Date of adminission mo. day yr.       10. Date of adminission mo. day yr.       10. Date of discharge from mo. day yr.         14. Date of first examination mo. day yr.       15. Date(s) of freatment mo. day yr.       16. Date of discharge from mo. day yr.       10. Date of discharge f	Record of Examination						
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26. If you have referred the employee to another physician provide the following:       Specialty         Name       27. What was the reason for this referral?         Address       27. What was the reason for this referral?         City       State       Zip         City       State       Zip         Signature       28. I certify that the statements in response to the questions asked above are true, complete and correct to the best of my knowledge. Further, I understand that any false or misleading statement or any misrepresentation or concealment of material fact which is knowingly made may subject me to felony criminal prosecution.         Signature of Physician							
Name       Address       27. What was the reason for this referral?         City       State       Zip       Consultation       Treatment         Signature       28. I certify that the statements in response to the questions asked above are true, complete and correct to the best of my knowledge. Further, I understand that any false or misleading statement or any misrepresentation or concealment of material fact which is knowingly made may subject me to felony criminal prosecution.         Signature of Physician	25. Remarks						
Name       Address       27. What was the reason for this referral?         City       State       Zip       Consultation       Treatment         Signature       28. I certify that the statements in response to the questions asked above are true, complete and correct to the best of my knowledge. Further, I understand that any false or misleading statement or any misrepresentation or concealment of material fact which is knowingly made may subject me to felony criminal prosecution.         Signature of Physician							
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City       State       Zip       Treatment         Signature       28. I certify that the statements in response to the questions asked above are true, complete and correct to the best of my knowledge. Further, I understand that any false or misleading statement or any misrepresentation or concealment of material fact which is knowingly made may subject me to felony criminal prosecution.         Signature of Physician	Name						
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Signature  28. I certify that the statements in response to the questions asked above are true, complete and correct to the best of my knowledge. Further, I understand that any false or misleading statement or any misrepresentation or concealment of material fact which is knowingly made may subject me to felony criminal prosecution.  Signature of PhysicianDate				<u> </u>			
Signature         28. I certify that the statements in response to the questions asked above are true, complete and correct to the best of my knowledge. Further, I understand that any false or misleading statement or any misrepresentation or concealment of material fact which is knowingly made may subject me to felony criminal prosecution.         Signature of Physician	City State Zip		ip				
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29. Name of Physician     30. Tax ID Number			Da				
	29. Name of Physician			30. Tax ID Num	nber		

Address		31. Do you specialize?		
			Yes No	
City	State	Zip	32. If yes, indicate specialty	
			Form CA-20	

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## FORM CA-20, PHYSICIAN'S REPORT

Compensation for wage loss cannot be paid unless medical evidence has been submitted supporting disability for work during the period claimed. For claims based on traumatic injury and reported on Form CA-1, the employee should detach Form CA-20, complete items 1-3 on the front, and print the OWCP district office address on the reverse. The form should be promptly referred to the attending physician for early completion. If the claim is for occupational disease, filed on Form CA-2, a medical report as described in the instructions accompanying that form is required in most cases. The employee should bring these requirements to the physician's attention. It may be necessary for the physician to provide a narrative medical report in place of or in addition to Form CA-20 to adequately explain and support the relationship of the disability to the employment.

For payment of a schedule award, the claimant must have a permanent loss or loss of function of one of the members of the body or organs enumerated in the regulations (20 C.F.R. 10.304). The attending physician must affirm that maximum medical improvement of the condition has been reached and should describe the functional loss and the resulting impairment in accordance with the American Medical Association **Guides to the Evaluation o Permanent Impairment**.

### PRIVACY ACT

In accordance with the Privacy Act of 1974 (Public Law No. 93-579, 5 U.S.C. 552a) and the Computer Matching and Privacy Protection Act of 1988 (Public Law No. 100-503), you are hereby notified that: (1) The Federal Employees' Compensation Act, as amended (5 U.S.C. 8101, et seq.) is administered by the Office of Workers' Compensation Programs of the U.S. Department of Labor. In accordance with this responsibility, the Office receives and maintains personal information on claimants and their immediate families. (2) The information will be used to determine eligibility for and the amount of benefits payable under the Act. (3) The information collected by this form and other information collected in relation to your compensation claim may be verified through computer matches. (4) The information may be given to Federal, State, and local agencies for law enforcement and for other lawful purposes in accordance with routine uses published by the Department of Labor in the Federal Register. (5) Failure to furnish all requested information may delay the process, or result in an unfavorable decision or a reduced level of benefits. (Disclosure of a social security number (SSN) is voluntary; the failure to disclose such number will not result in the denial of any right, benefit or privilege to which an individual may be entitled. Your SSN may be used to request information about you from

employers and others who know you, but only as allowed by law or Presidential directive. The information collected by using your SSN may be used for studies, statistics, and computer matching to benefit and payment files.)

THIS NOTICE SHOULD BE RETAINED FOR YOUR INFORMATION.

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**IMPORTANT:** A MEDICAL REPORT IS REQUIRED BY THE OFFICE OF WORKERS' COMPENSATION PROGRAMS BEFORE PAYMENT OF COMPENSATION FOR LOSS OF WAGES OR PERMANENT DISABILITY CAN BE MADE TO THE EMPLOYEE.

IF YOU HAVE SUBMITTED A NARRATIVE MEDICAL REPORT OR A FORM CA-16 TO OWCP WITHIN THE PAST 10 DAYS, YOU NEED NOT SUBMIT THIS FORM CA-20.

OWCP REQUIRES THAT MEDICAL BILLS, OTHER THAN HOSPITAL BILLS, BE SUBMIT-TED ON THE AMERICAN MEDICAL ASSOCIATION HEALTH INSURANCE CLAIM FORM, HCFA 1500/OWCP-1500a.

#### INSTRUCTIONS TO PHYSICIAN FOR COMPLETING ATTENDING PHYSICIAN'S REPORT

- 1. COMPLETE THE ENTRIES 1-32 ON THE FORM; AND
- 2. IF DISABILITY HAS NOT TERMINATED, INDICATE IN ITEM 17; AND
- 3. SEND THE FORM AND YOUR BILL TO:

OFFICE OF WORKERS' COMPENSATION PROGRAMS

#### **Public Burden Statement**

We estimate that it will take an average of 30 minutes to complete this collection of information, including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. If you have any comments regarding these estimates or any other aspect of this collection of information,

including suggestions for reducing this burden, send them to the Office of IRM Policy, U.S. Department of Labor, Room N1301, 200 Constitution Avenue, N.W., Washington, D.C. 20210; and to the Office of Management and Budget, Paperwork Reduction Project (1215-0103), Washington, D.C. 20503.