Send this form to the appropriate insurer:

Fax #

Progress Report
(Form AB-3)

Use this form for accidents that occur on or after October 1, 2004.

This part to be completed by the claimant or their representative or a Primary Health Care Practitioner

Insurance Company	
Policy Number:	
Date of Accident: (DD-MM-YYYY)	

Part 1
Claimant Information

Last Name	First Name	Date Of Birth (DD-MM-YYYY)
Date of Initial Assessment DD-MM-YYYY		

Part 2
Information of Primary Health Care Practitioner

Name of Professional		Profession
Address		
City, town or county	Province	Postal Code
Administrative Contact Name	Facility Name	
Telephone Number (Include area code)	Fax Number (Include area code)	

Part 3
Therapy Status Report

Diagnosis:

Key Subjective and Physical Examination Findings:

Functional Goals:	Progress towards goals
1.	☐ Regressed
	☐ improved minimally
2.	☐ Improved significantly
	☐ Resolved
	☐ Plateaued
3.	☐ Other (please describe)

Part 4
Signature of Primary Health Care Practitioner

Name (Please Print) _____

Signature _____ Date_____