Patient's Name: _____ Date of injury/onset of illness: _____
Last First MI

Describe findings and relevant diagnostic test results: _____

_____

_____

Explain how impairment % was determined: _____

_____

_____

☐ Disfigurement: (Describe findings) _____

_____

_____

☐ Non-Schedule losses: *(Identify impairment rating according to NY Impairment Guidelines. Attach separate sheet for additional body parts.)*

Body part: _____ Impairment: %_____

Describe findings and relevant diagnostic test results: _____

_____

_____

Explain how impairment % was determined: _____

_____

_____

☐ For multiple impairments from an injury/illness:

a. Combined aggregate impairment: %_____

b. Explain how % was determined: _____

_____

_____

3. Is patient working now? ☐ Yes at the pre-injury job ☐ Yes at other employment ☐ Not working

4. Does the patient have work limitations? ☐ Yes ☐ No If yes, check all of the following that apply:

☐ Bending/twisting	☐ Lifting	☐ Sitting
☐ Climbing stairs/ladders	☐ Operating heavy equipment	☐ Standing
☐ Environmental conditions	☐ Operation of motor vehicles	☐ Use of public transportation
☐ Kneeling	☐ Personal protective equipment	☐ Use of upper extremities

☐ Other (explain): _____

Describe/quantify the limitations: _____

_____

5. With whom have you discussed patient's returning to work and/or limitations? ☐ with patient ☐ with patient's employer ☐ N/A

6. Would patient benefit from vocational rehabilitation? ☐ Yes ☐ No If yes, explain _____

_____

This form is signed under penalty of perjury.

Board Authorized Health Care Provider signature:

_____ _____ _____ _____
Name Signature Specialty Date