State of California

Division of Workers Compensation

PRIMARY TREATING PHYSICIANS PROGRESS REPORT (PR-2)

Check the box(es) which indicate why you are submitting a report at this time. If the patient is Permanent and Stationary (i.e., has reached maximum medical improvement), do not use this form. You may use DWC Form PR-3 or IMC Form 81556.

Periodic Report (required 45 days after last report):	Change in treatment plan:	Released from care:
Change in work status:	Need for referral or consultation:	Response to request for information:
Change in Patients condition:	Need for surgery or hospitalization:	Other:

Patient:

Last: **Savage**	First: **Deborah**	M.I:	Sex: **Female**
Address: **1755 E. Roberts Ave, 111**	City : **Fresno**	State: **CA**	Zip: **93710 - 0000**
Date of Injury: **02-17-2020**	Date of Birth: **08-12-1965**		
Occupation: **Customer Service Rep**	SS: **XXX-XX-1746**	Phone:	
CLAIMS ADMINISTRATOR:			
Name: **ZURICH AMERICAN INSURANCE**	Contact:	Claim Number: **2230442292**	
Address:	City:	State:	Zip:
Phone:	FAX:	Email:	
Employer Name:	Employer Phone: **800 260-5570 x**		

The information below must be provided. You may use this form or you may substitute or append a narrative report.

Subjective complaints:

Objective Findings: (Include significant physical examination, laboratory, imaging, or other diagnostic findings.)

PLEASE SEE ATTACHED PROGRESS NOTE

Diagnoses:

Right wrist pain , Left wrist pain , Pain in left shoulder , Chronic right shoulder pain , Pain in finger of left hand , Left elbow pain , S/P carpal tunnel release , Right carpal tunnel syndrome , Ulnar neuropathy of left upper extremity , Carpal tunnel syndrome of left wrist

Treatment Plan:

Primary Treating Physician: (original signature, do not stamp) Date of exam: **09-25-2023**

I declare under penalty of perjury that this report is true and correct to the best of my knowledge and that I have not violated Labor Code 139.3.

Signature: 

Cal. Lic. #:

Executed at: **WorkMed California** Date: **09-25-2023**

Name: **Kevin Calhoun, M.D.** Specialty: **Occupational Medicine**

Address: **2440 w. Shaw ave. Suite Number 106 Fresno CA 93711 - 6850** Phone: **866 980-9580 x**

Next report due no later than: **PRN** (Use additional pages if necessary)