PART B - HEALTH CARE PROVIDER'S STATEMENT (Please Print or Type)

THE HEALTH CARE PROVIDER'S STATEMENT MUST BE FILLED IN COMPLETELY. THE ATTENDING HEALTH CARE PROVIDER SHALL COMPLETE AND RETURN TO THE CLAIMANT WITHIN SEVEN (7) DAYS OF RECEIPT OF THIS FORM. For item 7-d, you must give estimated date. If disability is caused by or arising in connection with pregnancy, enter estimated delivery date in item 7-e. **INCOMPLETE ANSWERS MAY DELAY PAYMENT OF BENEFITS**.

1. Last Name: P2_LastNameILastName First Name: P2_FirstNameIFirstName MI: P

2.Gender: ☐ Male ☐ Female 3. Date of Birth: P2 / P2 / P2

4. Diagnosis/Analysis: Left knee internal derangement Diagnosis Code: M23.92

a. Claimant's symptoms: Left knee pain 7/10, worse with ROM, difficulty rising from chair & going up or down stairs, unable to drive, lift heavy object, kneel, squat, negotiate stairs and exercise.

b. Objective findings: Limited and painful ROM, +McMurray, +PF grinding test

5. Claimant hospitalized?: ☐ Yes ☑ No From: fo / fo / form To: fo / fo / form

6. Operation indicated?: ☑ Yes ☐ No a. Type Left knee arthroscopy b. Date fo / fo / form

7. ENTER DATES FOR THE FOLLOWING	MONTH	DAY	YEAR
a Date of your first treatment for this disability	form1[0].#subform[1]._37	form1[0].#subform[1]._	form1[0].#subform[1]._
b. Date of your most recent treatment for this disability	form1[0].#subform[1]._37	form1[0].#subform[1]._	form1[0].#subform[1]._
c. Date Claimant was unable to work because of this disability	form1[0].#subform[1]._37	form1[0].#subform[1]._	form1[0].#subform[1]._
d. Date Claimant will again be able to perform work (Even if considerable question exists, estimate date. Avoid use of terms such as unknown or undetermined.)	form1[0].#subform[1]._37	form1[0].#subform[1]._	form1[0].#subform[1]._
e. If pregnancy related, please check box and enter the date ☐ estimated delivery date OR ☐ actual delivery date	form1[0].#subform[1]._37	form1[0].#subform[1]._	form1[0].#subform[1]._

8. In your opinion, is this disability the result of injury arising out of and in the course of employment or occupational disease?:
☐ Yes ☐ No If "Yes", has Form C-4 been filed with the Board? ☐ Yes ☐ No

I certify that I am a:

Physician (Physician, Chiropractor, Dentist, Podiatrist, Psychologist, Nurse-Midwife)

NY Licensed or Certified in the State of

166030 License Number

Christopher S Durant Health Care Provider's Printed Name

Health Care Provider's Signature

form1[0].#subform[1].dateSig Date

652 Suffolk Ave, Ste 210; Brentwood NY 11717 Health Care Provider's Address

631-617-5181 Phone #

IMPORTANT NOTICE TO CLAIMANT - READ THESE INSTRUCTIONS CAREFULLY

PLEASE NOTE: Do not date and file this form prior to your first date of disability. In order for your claim to be processed, Parts A and B must be completed.

1. If you are using this form because you became disabled **while employed** or you became disabled **within four (4) weeks after termination of employment**, your completed claim should be mailed **within thirty (30) days of your first date of disability to your employer or your last employer's insurance carrier**. You may find your employer's disability insurance carrier on the Workers' Compensation Board's website, www.wcb.ny.gov, using Employer Coverage Search.

2. If you are using this form because you became **disabled after having been unemployed for more than four (4) weeks**, your completed claim MUST be mailed to: **Workers' Compensation Board, Disability Benefits Bureau, PO Box 9029, Endicott, NY 13761-9029**. If you answered "Yes" to question 13.B.3, please complete and attach Form DB-450.1.

If you do not receive a response within 45 days or if you have questions about your disability benefits claim, please call your employer's insurance carrier. For general information about disability benefits, please visit www.wcb.ny.gov or call the Board's Disability Benefits Bureau at (877) 632-4996.

Notification Pursuant to the New York Personal Privacy Protection Law (Public Officers Law Article 6-A) and the Federal Privacy Act of 1974 (5 U.S.C. § 552a). The Workers' Compensation Board's (Board's) authority to request that claimants provide personal information, including their social security number, is derived from the Board's investigatory authority under Workers' Compensation Law (WCL) § 20, and its administrative authority under WCL § 142. This information is collected to assist the Board in investigating and administering claims in the most expedient manner possible and to help it maintain accurate claim records. Providing your social security number to the Board is voluntary. There is no penalty for failure to provide your social security number on this form; it will not result in a denial of your claim or a reduction in benefits. The Board will protect the confidentiality of all personal information in its possession, disclosing it only in furtherance of its official duties and in accordance with applicable state and federal law

HIPAA NOTICE - In order to adjudicate a workers' compensation claim or disability benefits claim, WCL 13-a(4)(a) and 12 NYCRR 325-1.3 require health care providers to regularly file medical reports of treatment with the Board and the insurance carrier or employer. Pursuant to 45 CFR 164.512 these legally required medical reports are exempt from HIPAA's restrictions on disclosure of health information.

Disclosure of Information: The Board will not disclose any information about your case to any unauthorized party without your consent. If you choose to have such information disclosed to an unauthorized part, you must file with the Board an original signed Form OC-110A "Claimants Authorization to Disclose Workers' Compensation Records." This form is available on the WCB website (**www.wcb.ny.gov**) and can be accessed by clicking the "Forms" link. If you do not have access to the internet please call (877) 632-4996 or visit our nearest Customer Service Center to obtain a copy of the form. In lieu of Form OC-110A, you may also submit an original signed, notarized authorization letter.

An employer or insurer, or any employee, agent, or person acting on behalf of an employer or insurer, who KNOWINGLY MAKES A FALSE STATEMENT OR REPRESENTATION as to a material fact in the course of reporting, investigation of, or adjusting a claim for any benefit or payment under this chapter for the purpose of avoiding provision of such payment or benefit SHALL BE GUILTY OF A CRIME AND SUBJECT TO SUBSTANTIAL FINES AND IMPRISONMENT.