# Workers' Compensation
# Attending Physician Benefits Form

**Please return completed form to the applicable entity regarding this claim.**
*(Private Carrier, Self-Insured, or Third Party Administrator (TPA) administering this claim)*

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|---|---|---|
| **Physician** | Claimant Name: | Social Security Number: |
| | Date of Injury: | Claim Number: |
| | Employer: | Physician Name: |
| | Estimated: ☐ Transitional ☐ Full Duty Return-To-Work Date: | |
| | Maximum Medical Improvement: ☐ Yes ☐ No | |
| | Ready for Permanent Partial Disability Rating: ☐ Yes ☐ No | |
| | Estimated Period of Disability From: To: | |
| | Current Appointment Date: | Next Appointment Date: |
| | Physicians completing this form are required to submit updated detailed medical reports to include current treatment plans related to this claim in a timely manner after each office visit. The completion of this form without the detailed medical information noted above does not guarantee that temporary total disability benefits will be paid.<br><br>Physician's signature:_____ Date: _____ | |

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|---|---|
| **Claimant** | Have you performed any kind of work or have you received income for any work during the time you have been certified temporarily and totally disabled? ☐ Yes ☐ No |
| | I hereby certify that the statement and answer set forth above are true and correct to the best of my knowledge and belief. I am aware that the law provides for severe penalties if I knowingly and with fraudulent intent withhold a material fact or make a false statement in order to obtain or increase a benefit to which I am not entitled.<br><br>Claimant's signature:_____ Date: _____ |

**Failure to complete this form in its entirety will affect the payment of temporary total disability benefits in this claim.**