MOHAWK SELF INSURANCE

MSI-3 *Physician's Report*

SECTION A
Physician Information

Physician Name:_____

Date of Examination:_____
Month day year

SECTION B
Patient's Name:_____

Date of Birth:_____

Diagnosis/Working Diagnosis:
(injury)_____

_____

SECTION C: Please indicate the patient's status and task limitations in relation to the diagnosis

☐ No Limitation ☐ No Return to Work (rationale required) ☐ Specified limitations

Explanation

_____

_____

_____

_____

_____

_____ _____

Physician Signature **Date** month day year

_____ _____

Claimant (Injured Worker) Signature **Date** month day year