NYS Workers' Compensation Board, Centralized Mailing, PO Box 5205, Binghamton, NY 13902-5205

CHECK TYPE OF DOCTOR

☐ PHYSICIAN ☐ CHIROPRACTOR

☐ PODIATRIST ☐ PSYCHOLOGIST

State of New York
WORKERS' COMPENSATION BOARD

THIS AGENCY EMPLOYS AND SERVES PEOPLE WITH DISABILITIES WITHOUT DISCRIMINATION.

MEDICAL PROOF OF CHANGE IN CONDITION IN SUPPORT OF APPLICATION FOR REOPENING OF CLAIM FOR WORKERS' COMPENSATION, VOLUNTEER FIRE FIGHTERS' OR VOLUNTEER AMBULANCE WORKERS' BENEFITS

This report must be signed personally by the attending doctor or by some other doctor having knowledge of the facts. If doctor renders treatment in a case, including treatment for an occupational disease, C-4 (or PS-4 by psychologists) reports must also be filed. File the signed original of each report with (1) CHAIR, WORKERS' COMPENSATION BOARD at the centralized mailing address listed above and file a signed copy with (2) the INSURANCE CARRIER, if known, or the EMPLOYER.

ANSWER ALL QUESTIONS FULLY - TYPEWRITER OR COMPUTER PREPARATION IS STRONGLY RECOMMENDED

WCB CASE NO. (If Known)	CARRIER CASE NO. (If Known)	DATE OF INJURY AND TIME	ADDRESS WHERE INJURY OCCURRED (City, Town or Village)	CLAIMANT'S SOCIAL SECURITY NO.

	NAME				ADDRESS	
INJURED PERSON*	First Name	Middle Initial	Last Name	Age		APT. NO.
EMPLOYER (at the time of accident)						
INSURANCE CARRIER						

** If patient claims that injury occurred while performing assigned duty as a Volunteer Firefighter or Volunteer Ambulance Worker, show as EMPLOYER the city, town, village, district or ambulance company against which the claim is made and enter "x" here:* VF/VAW ☐

1. (a) When did YOU first treat claimant? _____ (b) last treat claimant? _____ (c) Are you still treating? _____
2. State in patient's own words how accident or injury occurred: _____
3. Did you communicate with claimant's last attending doctor to ascertain medical findings present at time of discharge? _____
4. State the present pathology which in your opinion warrants a reopening of this case: _____
5. Describe treatment or apparatus now necessary: _____
6. Describe any present disability or condition not present at time case was last closed: _____
7. Is there any permanent defect? _____ If so, what is percentage loss or loss of use? _____
8. In your opinion was the accident or injury as above described a competent producing cause for the present findings and complaints? _____
9. Is claimant working? _____ (a) Able to do usual work? _____ When? _____
   (b) Able to do any work? When? _____
   (c) Specify work limitations, if any: _____
10. Name of latest employer _____ Last day worked _____
    Address _____

Typed or Printed Name of Attending Doctor _____

Address _____

Telephone No. _____ W.C.B. Authorization No. _____ W.C.B. Rating Code _____

PHYSICIANS COMPLETE THE FOLLOWING

I state that I am a physician, authorized by law to practice in the State of New York, am not a party to this proceeding, am the physician who subscribed to the above (or attached) report, have read the name and know the contents thereof; that the same is true to my knowledge, except as to the matters stated to be on information and belief, and as to those matters I believe it to be true. Affirmed as true under the penalty or perjury.

Written Signature (Facsimile Not Accepted) _____ Date _____

IMPORTANT: BY LAW CHIROPRACTOR'S, PODIATRIST'S AND PSYCHOLOGIST'S REPORTS MUST BE SWORN TO BEFORE A NOTARY PUBLIC.

State of New York)
ss:
County of _____) _____, being duly sworn, deposes and says: That (s)he is the _____, duly licensed in the State of New York, who subscribed to the above (or attached) report; and that (s)he has read the same and knows the contents thereof; that the same is true to the knowledge of deponent, except as to the matters stated to be on information and belief, and as to those matters (s)he believes it to be true.

Subscribed and sworn before me this

_____ day of _____, _____

_____
(Signature of Notary Public)

HIPAA NOTICE - In order to adjudicate a workers' compensation claim, WCL13-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 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.