NEW YORK STATE Workers' Compensation Board

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

PO Box 5205, Binghamton, NY 13902-5205 • Statewide Fax: (877) 533-0337

CHECK TYPE OF DOCTOR: ☐ Physician ☐ Chiropractor ☐ Podiatrist ☐ Psychologist

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 mailing address listed above and filed a signed copy with 2. the Insurance Carrier, if known, or the Employer.

Answer all questions and avoid use of indefinite terms. Typewriter or computer preparation is strongly recommended.

WCB Case No. (If Known)	Carrier Case No. (If Known)	Date of Injury (mm/dd/yyyy) and Time	Address Where Injury Occurred (City, Town or Village)	Claimant's Social Security No.

Injured Person* Name (First, Middle, Last) and Age	Injured Person Address (Include Apt. No.)
Employer Name (at the time of accident)	Employer Address
Insurer Name	Insurer Address

* 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. _____

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 change in permanent impairment or loss of use? _____
   If so, what is the change in impairment or schedule loss of use, using the current impairment guidelines? _____
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 _____

Type or Printed Name of Attending Doctor _____

Address _____

Telephone No. _____ WCB Authorization No. _____ WCB 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 BEFORE A NOTARY PUBLIC

State of New York) ss:

County of _____) _____ , being duly sworn, deposes and says:

That they are the _____ , duly licensed in the State of New York, who subscribed to the above (or attached) report; and that they have 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 they believe to be true.

Sworn to before me this _____ day of _____ 20____

_____

(Signature of Notary Public)

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