STATE OF CALIFORNIA

DOCTOR'S FIRST REPORT OF OCCUPATIONAL INJURY OR ILLNESS

Within 5 days of your initial examination, for every occupational injury or illness, send two copies of this report to the employer's workers' compensation insurance carrier or the insured employer. Failure to file a timely doctor's report may result in assessment of a civil penalty. In the case of diagnosed or suspected pesticide poisoning, send a copy of the report to Division of Labor Statistics and Research, P.O. Box 420603, San Francisco, CA 94142-0603, and notify your local health officer by telephone within 24 hours.

1. **INSURER NAME AND ADDRESS:** Joe Denham, 567 Insurance Blvd., Santa Rosa, CA 91840. Claim Number: 2346789XY	**PLEASE DO NOT USE THIS COLUMN**
2. **EMPLOYER NAME:** Ace Computers	**Case No.**
3. Address: 123 No. and Street: City: Employer City, CA Zip: 98756	**Industry**
4. Nature of business (e.g., food manufacturing, building construction, retailer of women's clothes.): Computer/Tech	**Country**
5. **PATIENT NAME** (first name, middle initial, last name): John M Doe / 6. Sex: Male / 7. Date of Birth: 11/01/1985	**Age**
8. Address: Employee Address No. and Street: City: Employee City Zip: 96570 / 9. Telephone number: (123) 456-7890	**Hazard**
10. Occupation (Specific job title): Computer/Tech / 11. Social Security Number: 123-45-6789	**Disease**
12. Injured at: 123, Employer City, CA 98756	**Hospitalization**
13. Date and hour of injury or onset of illness: 11/11/2015, 9:58 a.m. / 14. Date last worked: 11/01/2015	**Occupation**
15. Date and hour of first examination or treatment: 11/11/2015, 9:51 a.m. / 16. Have you (or your office) previously treated patient? No	**Return Date/Code**

Patient please complete this portion, if able to do so. Otherwise, doctor please complete immediately, inability or failure of a patient to complete this portion shall not affect his/her rights to workers' compensation under the California Labor Code.

17. **DESCRIBE HOW THE ACCIDENT OR EXPOSURE HAPPENED.** (Give specific object, machinery or chemical. Use reverse side if more space is required.) "Injury occurred when patient was lifting a computer monitor and "threw out his shoulder" ."

18. **SUBJECTIVE COMPLAINTS** (Describe fully. Use reverse side if more space is required.) Mr. Doe and I discuss his current complaints. (See next page)

19. **OBJECTIVE FINDINGS** (Use reverse side if more space is required.)

A. Physical examination: See next page for findings.

B. X-ray and laboratory results (State if non or pending.)

20. **DIAGNOSIS** (if occupational illness specify etiologic agent and duration of exposure.) Chemical/toxic compounds are NOT involved. (See next page)

21. Are your findings and diagnosis consistent with patient's account of injury or onset of illness?

22. Is there any other current condition that will impede or delay patient's recovery?

23. **TREATMENT RENDERED** (Use reverse side if more space is required.) Treatment is indicated. (See next page)

24. If further treatment required, specify treatment plan/estimated duration.

25. If hospitalized as inpatient, give hospital name and location.

26. WORK STATUS -- Is patient able to perform usual work? Yes with modifications The patient can return to his occupation with the modifications described below. Regular work (See next page)

Doctor's Signature	CA License Number: D12456
Doctor Name and Degree (please type): Claire Williams, MD	IRS Number
Address: 653 Alhambra St., Crockett, 94525, CA, US	Telephone Number: (707) 799-6326

FORM 5021 (Rev. 4)
1992

Any person who makes or causes to be made any knowingly false or fraudulent material statement or material representation for the purpose of obtaining or denying workers' compensation benefits or payments is guilty of a felony.

Doctor's First Report of Occupational Injury or Illness

Section 1. Insurance name and address: Joe Denham, 567 Insurance Blvd., Santa Rosa, CA 91840
Section 2. Employer Name: Ace Computers
Section 3. Employer Address: 123, Employer City, CA 98756
Section 4. Nature of business: Computer/Tech

Section 5. Patient Name: John M Doe
Section 6. Sex: Male
Section 7. Date of Birth: 11/01/1985
Section 8. Patient Address: Employee Address, Employee City, CA 96570
Section 9. Patient Telephone number: Home: (123) 456-7890 Cell: (123) 777-6666 Work: (123) 456-8900
Section 10. Occupation: Computer/Tech
Section 11. Social Security Number: 123-45-6789
Section 12. Injured at: 123, Employer City, CA 98756
Section 13. Date and hour of injury or onset of illness: 11/11/2015, 9:58 a.m.
Section 14. Date last worked: 11/01/2015
Section 15. Date and hour of first examination or treatment: 11/11/2015, 3:20 p.m.
Section 16. Have you (or your office) previously treated patient? No
Section 17. Describe how the accident or exposure happened: Injury occurred when patient was lifting a computer monitor and "threw out his shoulder"

History of Injury/Illness:
Mr. John Doe is a right-handed 30 year-old male who worked at Ace Computers at the time of his injury. His industrial injury occurred on 11/11/2015. The location of the injury/condition was the office. His right shoulder was injured due to lifting. The injury/condition was reported to: supervisor. After the injury occurred, he continued working.

Section 18. Subjective Complaints
Mr. Doe and I discuss his current complaints.

Shoulder - Right
He describes his pain quality as aching. He describes the intensity of his pain as 4 out of 10. He rates the frequency of his pain as occurring 50% of the time. Rest, ice, heat and stretching make the pain better. Lifting and twisting make the pain worse.

Section 19A. Objective Findings

Shoulder - Right
Shoulder Ranges of Motion Figure Table A1 page 596, Corrected with Errata March 2002: AMA Estimated Normal: Flexion (180D), Extension (40D), Abduction (180D), Adduction (30D), External Rotation (90), Internal Rotation (80D).
Flexion: Right 178 D Left 177 D
Extension: Right 39 D Left 40 D
Abduction: Right 180 D Left 180 D
Adduction: Right 29 D Left 30 D
External Rotation: Right 38 D Left 39 D
Internal Rotation: Right 78 D Left 80 D
Shoulder Manual Muscle Testing: 5/5 all directions.
Special Testing: Impingement: positive. Instability: negative.
Distal Neurovascular Exam: Intact light touch, intact 5/5 motor and intact reflexes.

Section 20. Diagnoses

Shoulder - Right
Strain of muscle(s) and tendon(s) of the rotator cuff of right shoulder. Initial encounter. ICD-10: S46.011A.
Incomplete rotator cuff tear or rupture of right shoulder, not specified as traumatic. ICD-10: M75.111.

Section 23. Treatment Rendered

Shoulder - Right
Treatment is indicated for the right shoulder. Ibuprofen (Motrin, Advil) (400 mg) is prescribed. Dispense total number: 1. 1 refill.

Section 26. Work Status
Return to clinic: Yes. 1 month.

Ability to Resume Usual and Customary Occupation
The employee can return to his occupation with the modifications described below.

Documentation

I declare under penalty of perjury that I have not violated the provisions of California Labor Code Section 139.3 with regard to the evaluation of this patient or the preparation of this report.
I verify under penalty of perjury that the total time I spend on the following activities is true and correct:

e-signed by Claire Williams, MD
10:30 p.m., September 15, 2015