State of California Additional pages attached ☑
Division of Workers' Compensation

PRIMARY TREATING PHYSICIAN'S PROGRESS REPORT (PR-2)

Check the boxes which indicate why you are submitting a report at this time. If the patient is "Permanent and Stationary" (i.e., has reached maximum medical improvement), do not use this form. You may use DWC Forms PR-3 or PR-4.

☐ Periodic Report (required 45 days after last report)	☑ Change in treatment plan	☐ Released from care
☑ Change in work status	☐ Need for referral or consultation	☐ Response to request for information
☑ Change in patient's condition	☐ Need for surgery or hospitalization	☑ Request for authorization
☐ Other:		

Patient:
Last: Doe First: John M.I.: M Sex: Male
Address: Employee Address City: Employee City State: CA Zip: 96570
Date of Injury: 11/11/2015 Date of Birth: 11/01/1985
Occupation: Computer/Tech SS#: 123-45-6789
Phone: Home: (123) 456-7890 Cell: (123) 777-6666 Work: (123) 456-8900

Claims Administrator:
Name: Jen Williams, Joe Denham Claim Number: 2346789XY
Address: 567 Insurance Blvd. City: Santa Rosa State: CA Zip: 91840
Phone: (567) 890-3133 ext. 2 Fax: (324) 567-8905
Email: jen@fourfivesix.com
Employer name: Ace Computers Employer phone: (123) 456-3235

The information below must be provided. You may use this form or you may substitute or append a narrative report.

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. At the time of his injury, patient had worked 3 years at his job. 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.

Subjective Complaints:
Mr. Doe and I discuss his current complaints.

Shoulder - Right
He reports that he has no symptoms associated with this injury and is not experiencing any pain.

Treatment Plan: (Include treatment rendered to date. List methods, frequency and duration of planned treatment(s). Specify consultation/referral, surgery, and hospitalization. Identify each physician and non-physician provider. Specify type, frequency and duration of physical medicine services (e.g., physical therapy, manipulation, acupuncture)). Use of CPT codes is encouraged. Have there been any changes in treatment plan? If so, why?

Shoulder - Right
Treatment is indicated for the right shoulder. Ibuprofen (Motrin, Advil) (600 mg) is prescribed.

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

Ability to Resume Usual and Customary Occupation
The employee can return to his occupation.

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:

Primary Treating Physician: Date of Exam: 11/15/2015

I declare under penalty of perjury that this report is true and correct to the best of my knowledge and that I have not violated Labor

Code 139.3.

Signature:

Executed at: Contra Costa

Name: Claire Williams

Address: 653 Alhambra St., Crockett, 94525, CA, US

Cal. Lic. # D12456

Date: 12/05/15, 3:22 p.m.

Specialty: Family Medicine

Phone: (707) 799-6326

e-signed by Claire Williams, MD