WORK SAFE. FOR LIFE.
WORKERS' COMPENSATION BOARD OF NOVA SCOTIA

Halifax Office
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Physician's Report Form 8/10

WCB Claim # *00000*

* *Mandatory Information*

* WORKER INFORMATION

Last Name	First Name	Initial	Date of Birth (dd / mm / yyyy)
Sample	*Patient*	*B*	*14* / *3* / *1982*

Street	City	Province	Postal Code	Health Card Number
123 Main St., Apt. 218	*Dartmouth, NS B2B 2B2*			*0001 000 009*

Home/Cell Phone	Work Phone	Employer Name	Worker's Job Title/Occupation
(902) 555-0248 work	*(902) 555-1729 cell*	*ACME Inc.*	*Test engineer*

* INJURY INFORMATION

Date of Injury: dd / mm / yyyy	Date of Visit: dd / mm / yyyy	Diagnosis: (specify body part)
26 / *5* / *2014*	*28* / *5* / *2014*	*CARDIAC ARREST*

Subjective Findings:
Imperdiet at erat. Vivamus in aliquam lacus. Vestibulum enim ligula, consequat eget aliquet a, suscipit at elit. Sed commodo turpis turpis, vel rhoncus purus cursus non. Integer leo eros, adipiscing nec nibh at, lobortis eleifend sapien. Quisque tincidunt risus non mi vehicula, non tempor dui cursus. Vestibulum at diam pellentesque odior.

Objective Findings:
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* RETURN-TO-WORK PLAN

Is the worker still working? [X] Yes [ ] No
Are transitional duties available? [X] Yes [ ] No [ ] Unknown

Expected return-to-work date (if applicable): [X] Transitional [ ] Pre-injury — dd: *4* / mm: *6* / yyyy: *2014*

Current Work Capabilities: (definitions on back) [ ] Sedentary [X] Light [ ] Medium [ ] Heavy [ ] Very Heavy [ ] N/A

Are you aware of any pre-existing or current problems/barriers that may influence recovery? [ ] Yes [X] No
If yes, please explain:

* TREATMENT PLAN

	Methodology/Goals	Timeframe
Treatment Plan	*Dit, molestie dolor sit amet, fringilla leo. Maecenas vel tortor dictum, adipiscing purus eget, euismod erat. Sed gravida nibh metus, quis mattis eros lacinia ut. Aenean et augue ut dolor sodales scelerisque quis vitae est. Proin ac faucibus diam phase.*	*Llus blandit dignissim eros id eleifend. Vivamus et feugiat dolor, ultrices consectetur urna. Cras placerat blandit urna a placerat.*

Medications, referrals, tests, Xrays, MRI, etc.:
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Follow-up Plan:
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* PHYSICIAN CERTIFICATION

I certify that this is a complete and accurate report; that the fees charged are in accordance with the WCB Contractual Fee Schedule; that I have received no prior payment; and that I have read the reporting responsibilities on the back of this form.

Physician's Name: *DR. REQUESTING PHYSICIAN*
Address: *123 Main St., Halifax, Nova Scotia B2B2B2*
Phone Number: *(902)111-1111*
Date: *2014/05/28*
WCB Physician #: *15779*

Practimax Plus Facsimile