

SUMMARY OF MEDICAL RECORD – OCCUPATIONAL EXPOSURE
(Please attach additional pages if necessary)

Petitioner's Name: _____ Date of Industrial Accident: _____
Employer's Name: _____

1. Diagnosis

What is your impression/diagnosis of the petitioner's medical problem(s)?

2. Causation/Aggravation

Did the petitioner's occupational exposure during employment with the employer medically cause or aggravate the medical problem(s) described above? **___Yes ___No**

If the occupational exposure during employment with the employer caused an aggravation of petitioner's medical problem(s), is it a _____ temporary or _____ permanent aggravation?

Is the sole cause of the petitioner's medical problem(s) described above due to the occupational exposure during employment with the employer? **___Yes ___No**

If no, please state separately and with specificity all other causes that have aggravated, prolonged, accelerated or in any way contributed to the petitioner's medical problem(s).

To what extent, by percentage, has another cause contributed to petitioner's medical problem(s)?

3. Work Release/Medical Stability

Have you released the petitioner from work as the result of the medical problem(s) caused or aggravated by the occupational exposure during employment with the employer? **___Yes ___No**

If yes, on what date? _____

Have you released the petitioner to work with medically prescribed functional limitations ("light duty") as the result of the medical problem(s) caused or aggravated by occupational exposure during employment with the employer? **___Yes ___No**

If yes, on what date and describe in detail the functional limitations? _____

Have you released the petitioner to return to work with no restrictions? **___Yes ___No**

If yes, on what date? _____

Is the petitioner medically stable (stabilization means that the period of healing has ended and the condition of the petitioner will not materially improve) with respect to the medical problem(s) caused or aggravated by the occupational exposure during employment with the employer? **___Yes ___No**

If yes, on what date (please identify separately a specific date of medical stability for each medical problem if more than one caused by the occupational exposure at issue.)?

4. Permanent Impairment

If the petitioner is medically stable, what is the percentage of permanent impairment, based upon Utah Code §34A-2-412 or the American Medical Association's "Guides to the Evaluation of Permanent Impairment, Fifth Edition" as modified by "Utah's 2006 Impairment Guides," that is attributable to the petitioner's medical problem(s) caused or aggravated by occupational exposure during employment with the employer? _____

Does the petitioner have medically prescribed permanent functional restrictions as the result of the occupational exposure during employment with the employer? ☐ **Yes** ☐ **No**

If yes, please describe in detail:

5. Medical Treatment

What treatment has been provided to date that was necessary to treat the petitioner's medical problem(s) caused or aggravated by occupational exposure during employment with the employer?

What necessary medical treatment are you currently recommending to treat the petitioner's medical problem(s) caused or aggravated by occupational exposure during employment with the employer?

6. Permanent Total Disability Cases.

If you found that the petitioner is permanently and totally disabled, please describe in detail each and every medically prescribed functional restriction on petitioner's activities and the specific medical problem causing the restriction.

Dated this _____ day of _____, 20____.

Physician's Name (please print)

Physician's Specialty

Physician's Signature

Physician's Street Address

Physician's City/State/Zip

Physician's Telephone Number