Employee's WCF No……

WCC-2A

INITIAL MEDICAL REPORT

(Made under regulation 21(1))

(This form shall be filled by medical practitioner in triplicate)

A. EMPLOYEE'S PARTICULARS

First Name……. Middle Name ……. Last Name …….

Date of birth……. Medical File no……. Job Title…….

Employer's Name. ……. Employee's ID No…….

B. **PARTICULARS OF HEALTH CARE PROVIDER**

Name of health care provider ……..……...

Contact address ……...…… Region/District …….……...

C. PARTICULARS OF OCCUPATIONAL ACCIDENT OR DISEASE

i. Date of accident or diagnosis of occupational disease……...

ii. Date of first consultation at this facility…….……

iii. Description of injuries/condition of the employee at the time of examination

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……

……

iv. Diagnosis……

D. MEDICAL PRACTITIONER'S ASSESSMENT

i. Does the employee require hospitalization? (Yes/No). ***Circle appropriately***

If Yes, which unit? ……..…

ii. Does the employee require follow up visit? (Yes/No). ***Circle appropriately***

If Yes, when is the next visit? ……./……/……..

iii. Is employee able to resume his duties? (Yes/No). ***Circle appropriately***

If No, exempted duty days……..…; From: …….……. To: …….

Reason: ……...

light duty days……...; From: …….. To: ……

Reason: ……...

iv. Practitioner's remarks

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DECLARATION

I declare that what I have stated herein above is true to the best of my knowledge.

Name of medical practitioner……. Designation ……

Registration No……... Cell phone…… E-mail……...

Signature……..... Date…….....

Official stamp