Employee's WCF No……

WCP-3

WORKERS COMPENSATION FUND
MEDICAL PROGRESS REPORT FORM

(This form shall be filled by a medical practitioner)

A. Name and address of health care provider

……
……

B. Type of medical progress (Mark (√) appropriately)

In the ward		Scheduled visit		Others (specify)	

C. Employee/Patient identification

Med treatment file No.	Name of the patient	Sex	Date of Birth

D. Medical care services details

Date of care	Diagnosis	Condition of the patient (major clinical findings from history, physical examination and tests)	Summary description of health care services rendered (type of consultation, medications, medical tests, procedures etc.)	Date of next visit	Additional Duty Exemption Days Given

Medical 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