Employee's WCF No*……………………….*

WCC-2B

MEDICAL PRACTITIONER'S REPORT

(Made under regulation 21(2))

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

A. EMPLOYEE'S PARTICULARS

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

Medical File no…………………………… Employer's Name. ………………………..……………….

B. DETAILS OF SERVICES RENDERED

i. Hospitalisation (fill appropriately)

Date of Admission	Date of Discharge	Reason

ii. Medical investigations, procedures and surgeries done

a) Investigations………………………………………………………………………………….…

b) Procedures………………………………………………………………………………………

c) Surgeries

Date of surgery	Type	Indication (s)	Anaesthesia	Surgeon's name and qualification

C. CURRENT STATE OF EMPLOYEE (PATIENT) (MARK (√) IN THE APPROPRIATE BOX)

i. Employee status

Fully recovered (Resumed duties without permanent loss of body part/function)	**Recovered with permanent loss of body part/function (Go to table (ii) below)**	**Need medical follow up** (Outcome not yet fully decided)	**Death** (Cause of death)

ii. For permanent loss of body part (s) or function (s) (complete table below)

Body part or function(s) impacted/affected	Manner of loss	Degree of Functions impaired or Level of loss of body part	Rehabilitation recommended

iii. Date when declared fit returning to work with /without restrictions……/……/………

D. FINAL DIAGNOSIS

i. What is the final diagnosis? ……………………………………………………….………………...

ii. Do you think this condition is occupational? (Yes/No). ***Circle appropriately***.
Why?
……………………………………………………………………………………………………….

iii. Medical practitioner's opinions and recommendations
……………………………………………………………………………………………………….
……………………………………………………………………………………………………….

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