



**WORKERS COMPENSATION FUND
MEDICAL PROGRESS REPORT FORM**

(This form shall be filled by a medical practitioner)

A. Name and address of health care provider

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

In the ward		Scheduled visit		Others (specify)	
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C. Employee/Patient identification

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

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.)

(Mark (√) appropriately)

Admitted	Date of next visit (in case of scheduled visit)	Referred (attach copy of referral form)	Discharged from the ward (attach copy discharge form)	Discharge from care (attach copy of return to work medical certificate)

Medical practitioner's remarks

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Name of the medical practitioner.....Reg No.

Designation.....Date.....

Signature and Official stamp.....