Tennessee Bureau of Workers' Compensation
220 French Landing Drive, I-B
Nashville, TN 37243-1002
800-332-2667

FORM C-32

STANDARD FORM MEDICAL REPORT FOR INDUSTRIAL INJURIES

This form may be used to introduce direct testimony in lieu of a physician's deposition and should bear the original signature of the physician making the report.

STATE FILE # __________________ DATE OF INJURY __________________ DATE OF MMI __________________

PATIENT NAME ____ SSN ______________________________________

DATE OF FIRST EVALUATION _______________________ DATE OF FINAL EVALUATION ___________________

EMPLOYER ____

Form completed by the: Evaluating Physician Treating Physician

PLEASE PROVIDE A NARRATIVE SUMMARY OF THE COURSE OF TREATMENT ____________________

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____

WORK STATUS

As a result of this injury, did you take the patient completely off work? Yes No

If "yes", please provide the period(s) of time during which the patient was completely off work.

From		**To**	
From		**To**	
From		**To**	

As a result of this injury, did you recommend the patient return to work with restrictions? Yes No

If "yes", please provide the period(s) of time during which the patient could return to work with restrictions.

From		**To**	
From		**To**	
From		**To**	

As a result of this injury, did you assign any permanent restrictions? Yes No

If yes, please describe or attach those permanent restrictions:

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PERMANENT IMPAIRMENT

a. Date of MMI: ________________________

b. Please attach a **Final Medical Report—Form C-30A**

c. If you feel that the applicable edition of the *AMA Guides* does not adequately assess the medical impairment of the patient, please express an impairment that you think is appropriate and attach a detailed explanation of how you arrived at the following percentage:

________ % scheduled member ________ % whole body

CAUSATION

For injuries occurring *on or after* July 1, 2014 only, your responses to the following questions must reflect your opinion to a reasonable degree of medical certainty, as opposed to speculation or possibility. In determining medical causation, you should consider all possible causes of the injury. The injury would be medically caused by employment if the employment activity, more likely than not, is primarily responsible for the injury or, primarily responsible for the need for treatment.

In this context, "more likely than not" and "primarily" both carry the meaning of greater than fifty percent.

What was the injury? ____

What was the mechanism of injury? ____

Was there a specific incident or series of incidents identified that brought about the injury? Yes No

If "yes", please describe:
____

Did the injury result in a need for treatment? Yes No

Did the injury result in any disablement (time off work or restricted duty, temporary or permanent)? Yes No

Was the employment activity, more likely than not, primarily responsible for the injury or primarily responsible for the need for treatment? Yes No

An aggravation of pre-existing disease, condition or ailment may be medically caused by the employment activity if the employment activity is primarily responsible for advancing or making worse the pre-existing disease, condition or ailment. Further, the need for treatment is medically caused if the employment activity is primarily responsible for the need for treatment.

Did this injury involve the aggravation of a pre-existing injury? Yes No

If "yes", was the employment activity primarily responsible for advancing or making worse the pre-existing disease, condition or ailment? Yes No

Was the employment activity primarily responsible for the present need for treatment of the pre-existing disease, condition or ailment? Yes No

<u>For injuries occurring *prior to* July 1, 2014</u> only, please answer the following question:

From a medical standpoint, considering the nature of the patient's occupation and medical history along with the diagnosis and treatment, did this injury more probably than not arise out of the patient's employment? Yes No

PHYSICIAN CERTIFICATION AND QUALIFICATIONS

I certify that the information furnished is correct and am aware that my signature attests to its accuracy. I further certify that all opinions are formulated within a reasonable degree of medical certainty. I further certify that my *curriculum vitae* (CV) is attached and that it is accurate.

Physician's Original Signature: ____ Date: _______________________

Please print full name of physician ____