MEDICAL REPORT ON INDUSTRIAL INJURY

Department of Workforce Development
Worker's Compensation Division
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The provision of your social security number is voluntary. Failure to provide it may result in an information processing delay. Personal information you provide may be used for secondary purposes [Privacy Law, s. 15.04(1)(m)].

PATIENT

WC Claim Number	Employee Name: EARL MILLER	
Social Security Number	Employee Address	
Injury Date: 9-14-07	Employer Name	Insurance Company

HISTORY

History as described by patient: Left hand was injured - severe crush while working with a brake press in the prison

DIAGNOSIS (Please be as detailed as possible)

Crushed left hand

PERMANENT DISABILITY (Describe permanent elements of disability such as limitation of motion, pain, weakness, etc. and describe effect on working ability)

What amputation present? yes — Comparative x-rays taken? ☒ Yes ☐ No — Stump: ☐ hardy or ☒ tender

Has permanent disability resulted? ☐ Yes ☐ No — Date of Last Exam: 2/26/10 — Has healing period ended? ☒ Yes ☐ No — Patient discharged? ☒ Yes ☐ No

Description of permanent disability. (Record motion losses on reverse)
AMPUTATION LEFT HAND AND DISTAL FOREARM

Was surgery performed as a result of accident? ☒ Yes ☐ No — If Yes, state type of surgery:
amputation left hand

If healing has not ended, what is minimum permanent disability expected?

PRIOR DISABILITY

What previous disability? -0-

PROGNOSIS

Prognosis

Date injured was or will be able to return to a limited type of work, and state any limitations:

Date injured was or will be able to return to full-time work subject only to permanent limitations:

What further treatment should be given?

Additional comments, if any:

Date: 8/23/12	City: MADISON	Physician or Chiropractor Signature (in own writing) [signature]
	Phone No. 608-263-1223	Typed or Printed Name: Venkat Rao

WKC-16 (R. 07/2001)