

**AFFIDAVIT OF PHYSICIAN PER SECTION 28-33-8(c) OF THE  
RHODE ISLAND WORKERS' COMPENSATION ACT**

State of Rhode Island  
Workers' Compensation Court  
Medical Advisory Board  
One Dorrance Plaza, Providence, RI 02903  
Phone: 401-458-3460  
TDD: 401-458-5275

**EMPLOYEE INFORMATION:**

Social Security No.: \_\_\_\_\_  
Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

**EMPLOYER INFORMATION:**

FEIN: \_\_\_\_\_  
Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone: \_\_\_\_\_

**IF THE IDENTITY OF THE INSURER IS UNKNOWN, CONTACT THE DIVISION OF WORKERS' COMPENSATION AT (401) 462-8116 FOR THE INFORMATION.**

**INSURANCE CARRIER:**

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone: \_\_\_\_\_

**ADJUSTING COMPANY:**

Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Phone: \_\_\_\_\_

**EMPLOYEE'S INJURY INFORMATION:**

Injury Date: \_\_\_\_\_

Incapacity Date: \_\_\_\_\_

PREPARED FOR THE WEEK AFTER EMPLOYEE'S DATE OF INJURY INDICATED BELOW  
Six \_\_\_\_\_ Twelve \_\_\_\_\_ Eighteen \_\_\_\_\_ Other \_\_\_\_\_

**SECTION 28-33-8(b) OF THE RHODE ISLAND WORKERS' COMPENSATION ACT PROVIDES FOR A \$20.00 FEE TO BE CHARGED FOR THE TIMELY FILING OF THIS FORM WITHIN ONE WEEK OF THE DUE DATE.**

Now comes the undersigned Physician and after first being duly sworn on oath makes affidavit and states:

1. The nature of the injury for which this employee is being treated is as follows:

Diagnosis: \_\_\_\_\_ ICD 9 Code: \_\_\_\_\_

Diagnosis: \_\_\_\_\_ ICD 9 Code: \_\_\_\_\_

Diagnosis: \_\_\_\_\_ ICD 9 Code: \_\_\_\_\_

2. The type of treatment provided to date, including frequency, is as follows:

Diagnostic Tests Performed: \_\_\_\_\_

Medication Prescribed: \_\_\_\_\_

Referred for Rehab.: \_\_\_\_\_ Facility: \_\_\_\_\_

Surgery: \_\_\_\_\_

Other Treatment Provided: \_\_\_\_\_

3. Anticipated further treatment, including type, frequency, and duration of treatment(s) is as follows: (If none, so state.)

Diagnostic Tests: \_\_\_\_\_

Medication: \_\_\_\_\_

Referred for Rehab: \_\_\_\_\_ Facility: \_\_\_\_\_

Surgery: \_\_\_\_\_

Other Treatment Provided: \_\_\_\_\_

4. (a) Is it possible that this treatment may fall outside the Medical Advisory Board Protocols?

Yes or No \_\_\_\_\_

(b) If the answer is Yes, please substantiate in detail.

5. The employee's anticipated date of discharge is as follows: (If the employee has already been discharged, so state.) \_\_\_\_\_

6. Can the employee return to his or her former position of employment? Yes or No \_\_\_\_\_

7. (a) If the employee cannot return to his or her former position of employment, is the employee capable of work other than his or her former position of employment: Yes or No. \_\_\_\_\_

(b) The employee's work restrictions/capabilities are as follows: (If none, so state.) \_\_\_\_\_

8. (a) Has the employee reached maximum medical improvement? Yes or No \_\_\_\_\_ If and only if the employee has reached maximum medical improvement, set forth the employee's degree of functional impairment, if any, based upon the most recent edition of the *American Medical Association's Guide to Evaluation of Permanent Impairment* or comparable publications of the American Medical Association:

Specify: % of Whole Body \_\_\_\_\_ % of Body Part \_\_\_\_\_

Indicate Body Part \_\_\_\_\_

(b) If the employee has not reached maximum medical improvement, the time when the employee is expected to reach maximum medical improvement is as follows: # of weeks \_\_\_\_\_ or # of months \_\_\_\_\_

9. The within-named physician and/or the within-named treatment facility has an ownership interest in an ancillary facility(s) to which this employee has been referred for treatment of this injury which is described as follows:

(If none, so state.) \_\_\_\_\_

Physician's Signature \_\_\_\_\_ Lic. # \_\_\_\_\_ Date: \_\_\_\_\_

Physician's Name \_\_\_\_\_ Title \_\_\_\_\_

Phys. Asst. Sig. \_\_\_\_\_ Supervising Phys. Name \_\_\_\_\_

Name of Facility \_\_\_\_\_

Facility Address \_\_\_\_\_

Subscribed and sworn to before me by the above-named physician this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_

\_\_\_\_\_  
Notary Public

My Commission Expires: \_\_\_\_\_