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

◯ TEN (10) ◯ TWENTY (20) ◯ THIRTY (30) ◯ OTHER _____

EMPLOYEE INFORMATION

XXX-XX- _____ Date of Birth: _____
Social Security No. (last 4 digits only)

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

EMPLOYER INFORMATION

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

IF IDENTITY OF THE INSURER IS UNKNOWN, CONTACT THE DIVISION OF WORKERS' COMPENSATION AT (401) 462-8100 FOR THE INFORMATION.

INSURANCE CARRIER:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

EMPLOYEE'S INJURY INFORMATION:

Injury Date: _____

Incapacity Date: _____

SECTION 28-33-8 (b) OF THE RHODE ISLAND WORKERS' COMPENSATION ACT PROVIDES FOR A $30.00 FEE TO BE CHARGED FOR THE TIMELY FILING OF THIS FORM.

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

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

3. Can the employee return to his or her former position of employment? Yes or No _____

4. (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:

- ☐ no operating heavy machinery or vehicles
- ☐ no climbing ladders or stairs
- ☐ may lift up to _____ lbs. only
- ☐ no reaching above shoulders
- ☐ no repetitive twisting, bending
- ☐ no repetitive stooping, kneeling, squatting
- ☐ no push /pull _____ lbs.
- ☐ alternate standing/sitting
- ☐ no work involving use of right/left _____
- ☐ sit down work only
- ☐ keep wound clean and dry
- ☐ other _____

5. Has the employee reached maximum medical improvement? Yes or No _____

Physician's Signature _____ Lic # _____ Date: _____

Physician's Name _____ Title _____

Name of Facility _____ Address of Facility _____

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

Notary Public _____

My Commission Expires _____

MAB01 - ORIGINAL , SIGNED AND NOTARIZED - MEDICAL ADVISORY BOARD, COPY TO INSURER/SELF-INSURED EMPLOYER, COPY TO PHYSICIAN'S FILE, COPY TO EMPLOYEE AND HIS/HER ATTORNEY
August 2020

Print Form