

Dr. \_\_\_\_\_  
Name Street Address City State

Superintendent of \_\_\_\_\_ Hospital in \_\_\_\_\_  
City State

I hereby authorize and direct you, to give to The State of Ohio or its representative, any and all information, which he, she or it, may desire and which may have been acquired by you while attending in a professional capacity \_\_\_\_\_ and hereby waive as The State of Ohio \_\_\_\_\_, or its representative, all provisions of law prohibiting any physician or surgeon who has attended, or is attending \_\_\_\_\_, or any hospital to which I was confined, or am confined, from disclosing any and all information thereby acquired. A photocopy hereof shall be as valid as the original.

Dated \_\_\_\_\_, 20\_\_\_\_ Signed \_\_\_\_\_  
Address \_\_\_\_\_

### MEDICAL REPORT

<b>THE PATIENT</b>	Name of injured person _____ Age _____ Sex _____ Address: _____ City _____ State _____ Name and Address of Employer _____
<b>THE ACCIDENT</b>	Date of Accident: _____ Hour _____ m. Date Total Disability Began _____ State in patient's own words where and how accident occurred: _____ _____ _____
<b>THE INJURY</b>	Give accurate description of nature and extent of injury and state your findings: _____ _____ _____ Will the injury result in a permanent defect? _____ If so, what? _____ Is accident above referred to the only cause of patient's condition? _____ If not, state the contributing causes: _____ Is patient suffering from any disease or any other disabling condition NOT due to this accident? _____ Give particulars _____ Has patient any physical impairment due to previous accident or disease? _____ Give particulars _____ Has normal recovery been delayed for any reason? _____ Give particulars _____ _____ _____
<b>TREATMENT</b>	Date of your first treatment: _____ Where rendered (Office, Hospital, Home, etc.) _____ Describe treatment given by you _____ Were X-rays taken? _____ By whom? _____ When? _____ Name and Address _____ X-Ray findings _____ Was patient treated by anyone else? _____ By whom? _____ When? _____ Name and Address _____ Was patient hospitalized? _____ Name and Address of Hospital _____ Date of Admittance to hospital _____ 20____ Date of Discharge _____ 20____ Is further treatment needed? _____ For how long? _____

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Patient was/will be able to resume regular duties on: \_\_\_\_\_

**DISABILITY** Patient was/will be able to resume partial duties on: \_\_\_\_\_

If death ensued, give date? \_\_\_\_\_

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I am a duly licensed physician in the State of \_\_\_\_\_

I was graduated from \_\_\_\_\_ Medical School in \_\_\_\_\_ Year \_\_\_\_\_

Date of this report: \_\_\_\_\_ 20 \_\_\_\_\_

Signed: \_\_\_\_\_

Address: \_\_\_\_\_

Phone #: \_\_\_\_\_

**(This report must be signed personally by physician)**