Request for Workers' Compensation Medical Information

GRANITE INSURANCE

Injured Employee Name:	
Employer Contact Name:	
Employer Email:	Phone:
Date of Injury:	Date of Visit:

Dear Physician:

Thank you very much for promptly providing quality treatment to our valuable employee. There is some information we will need after each office visit to help our employee through the injury process. We appreciate your assistance in noting in your records (or keeping a copy for your records) the completion of the following information that should be completed and given to our employee to be returned to us after each appointment.

1. Diagnosis:

2. Is the injured employee able to return to full duty work?	
☐ Yes | Date:	☐ No

3. If no, is the injured employee able to return to transitional (light or modified) duty?	
☐ Yes | Date:	☐ No

4. If yes,	
Restrictions?	For how long?

5. Date of next appointment:
Comments:

6. Clinic Contact:	Phone:

Thanking you in advance for the excellent care you will give to our injured employee and your assistance in their timely transition back to work.