Saskatchewan Workers' Compensation Board
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TXP

Click on any field to start editing.

Reset Form

WCB claim number: _____

Worker's name: _____

Clinic name: _____ Clinic number: _____ Care provider number: _____ Phone: _____ Fax: _____ Care provider's name, address, postal code	Provincial Health Number: _____ Date of birth: (MM/DD/YYYY) Phone: _____ Employer name: _____ Worker's name, address, postal code

Injury

1. Worker's current complaints:

2. Clinical findings:

3. Describe other conditions not related to the work injury that may affect recovery:

4. Progress towards treatment goals (functional abilities required to return to work):

5. Identify any impediments to recovery:

6. Treatment plan:

7. Worker is currently working: ☐ Yes ☐ No If no, expected return to work date: (MM/DD/YYYY)

If yes, when did worker return? (MM/DD/YYYY)

8. Dates absent: _____

9. Dates of treatment since last report: _____

10. Date of next appointment: (MM/DD/YYYY) 11. Expected discharge date: (MM/DD/YYYY)

12. Frequency of appointments: _____

Signature: Please sign form before mailing/faxing. Date: _____ Copy to: _____