Form 113b Revised 3/2010

SUMMARY OF MEDICAL RECORD – OCCUPATIONAL EXPOSURE
(Please attach additional pages if necessary)

Petitioner's Name: ______________________________ Date of Industrial Accident: _____________
Employer's Name: ______________________________

1. Diagnosis

What is your impression/diagnosis of the petitioner's medical problem(s)?

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2. Causation/Aggravation

Did the petitioner's occupational exposure during employment with the employer medically cause or aggravate the medical problem(s) described above? ___**Yes** ____**No**

If the occupational exposure during employment with the employer caused an aggravation of petitioner's medical problem(s), is it a _____ temporary or ______ permanent aggravation?

Is the sole cause of the petitioner's medical problem(s) described above due to the occupational exposure during employment with the employer? ___**Yes** ____**No**
If no, please state separately and with specificity all other causes that have aggravated, prolonged, accelerated or in any way contributed to the petitioner's medical problem(s).

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To what extent, by percentage, has another cause contributed to petitioner's medical problem(s)?
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3. Work Release/Medical Stability

Have you released the petitioner from work as the result of the medical problem(s) caused or aggravated by the occupational exposure during employment with the employer? ___**Yes** ____**No**
If yes, on what date? ______________________________________

Have you released the petitioner to work with medically prescribed functional limitations ("light duty") as the result of the medical problem(s) caused or aggravated by occupational exposure during employment with the employer? ___**Yes** ____**No**
If yes, on what date and describe in detail the functional limitations? ____________________________

Have you released the petitioner to return to work with no restrictions? ___**Yes** ____**No**
If yes, on what date? ____
Is the petitioner medically stable (stabilization means that the period of healing has ended and the condition of the petitioner will not materially improve) with respect to the medical problem(s) caused or aggravated by the occupational exposure during employment with the employer? ___**Yes** ____**No**

If yes, on what date (please identify separately a specific date of medical stability for each medical problem if more than one caused by the occupational exposure at issue.)?

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4. **Permanent Impairment**

If the petitioner is medically stable, what is the percentage of permanent impairment, based upon Utah Code §34A-2-412 or the American Medical Association's "Guides to the Evaluation of Permanent Impairment, Fifth Edition" as modified by "Utah's 2006 Impairment Guides," that is attributable to the petitioner's medical problem(s) caused or aggravated by occupational exposure during employment with the employer? ____

Does the petitioner have medically prescribed permanent functional restrictions as the result of the occupational exposure during employment with the employer? **___Yes ____No**
If yes, please describe in detail:

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5. **Medical Treatment**

What treatment has been provided to date that was necessary to treat the petitioner's medical problem(s) caused or aggravated by occupational exposure during employment with the employer?

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What necessary medical treatment are you currently recommending to treat the petitioner's medical problem(s) caused or aggravated by occupational exposure during employment with the employer?

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6. **Permanent Total Disability Cases.**

If you found that the petitioner is permanently and totally disabled, please describe in detail each and every medically prescribed functional restriction on petitioner's activities and the specific medical problem causing the restriction.

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Dated this ______ day of __________________, 20____.

______________________________	______________________________
Physician's Name (please print)	Physician's Specialty
______________________________	______________________________
Physician's Signature	Physician's Street Address
______________________________	______________________________
Physician's City/State/Zip	Physician's Telephone Number