ATTACHMENT G

U.S. Department of Labor Form CA-16: Authorization for Examination and/or Treatment
(Two Pages)

PART B - ATTENDING PHYSICIAN'S REPORT

14. Employee's Name (last, first, middle)

15. What History of Injury or Disease Did Employee Give You?

16. Is there any History or Evidence of Concurrent or Pre-existing Injury, Disease, or Physical Impairment? (If yes, please describe)
☐ Yes ☐ No

16a. IDC-9 Code

17. What are Your Findings? (Include results of X-rays, laboratory tests, etc.)

18. What is Your Diagnosis?

18a. IDC-9 Code

19. Do You Believe the Condition Found was Caused or Aggravated by the Employment Activity Described? (Please explain your answer if there is doubt)
☐ Yes ☐ No

20. Did Injury Require Hospitalization? ☐ Yes ☐ No
If yes, date of admission (mo., day, year)
Date of discharge (mo., day, year)

21. Is Additional Hospitalization Required?
☐ Yes ☐ No

22. Surgery (If any, describe type)

23. Date Surgery Performed (mo., day, year)

24. What (Other) Type of Treatment Did You Provide?

25. What Permanent Effects, If Any, Do You Anticipate?

26. Date of First Examination (mo., day, year)

27. Date(s) of Treatment (mo., day, year)

28. Date of Discharge from Treatment (mo., day, year)

29. Period of Disability (mo., day, year) (If termination date unknown, so indicate)
Total Disability: From To
Partial Disability: From To

30. Is Employee Able to Resume
☐ Light Work Date:
☐ Regular Work Date:

31. If Employee is Able to Resume Work, Has He/She been Advised? ☐ Yes ☐ No If Yes, Furnish Date Advised

32. If Employee is Able to Resume Only Light Work, Indicate the Extent of Physical Limitations and the Type of Work that Could Reasonably be Performed with these Limitations.

33. General Remarks and Recommendations for Future Care, if Indicated. If you have made a Referral to Another Physician or to a Medical Facility, Provide Name and Address.

34. Do You Specialize? ☐ Yes ☐ No (If yes, state specialty)

35. SIGNATURE OF PHYSICIAN. I certify that all the statements in response to the questions asked in Part B of this form are true, complete and correct to the best of my knowledge. Further, I understand that any false or misleading statement or any misrepresentation or concealment of material fact which is knowlingly made may subject me to felony criminal prosecution.

36. Address (No., Street, City, State, ZIP Code)

37. Tax Identification Number

38. National Provider System Number

39. Date of Report

MEDICAL BILL: Charges for your services should be presented to the AMA standard "Health Insurance Claim From" (AMA OP 407/408/409; OWCP-1500a, or HCFA 1500). Service must be itemized by Current Procedural Terminology Code (CPT 4) and the form must be signed.

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