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|-----------------------------------------------------------------------------------------------------|--|------|--|-------------------------------------------------------------------------|--|-----------------------------|--|----------------------|--|------------------|
| 2. EMPLOYER NAME                                                                                    |  |      |  |                                                                         |  |                             |  |                      |  | 3. Date of Birth |
| 4. Address                                                                                          |  | City |  | State                                                                   |  | Zip                         |  |                      |  | 4. Injury        |
| 5. Nature of business (e.g., food manufacturing, building construction, retail of women's clothing) |  |      |  |                                                                         |  |                             |  |                      |  | 5. Injury        |
| 6. EMPLOYEE NAME (surname, middle initial, first name)                                              |  |      |  | 7. Sex<br><input type="checkbox"/> Male <input type="checkbox"/> Female |  | 8. Date of Birth            |  | 9. M. Day Yr.<br>/ / |  | 6. Injury        |
| 10. Address                                                                                         |  | City |  | State                                                                   |  | 11. Telephone number<br>/ / |  |                      |  | 7. Injury        |
| 12. Occupation (specify job title)                                                                  |  |      |  |                                                                         |  |                             |  |                      |  | 8. Injury        |
| 13. Employer's address                                                                              |  |      |  |                                                                         |  |                             |  |                      |  | 9. Injury        |
| 14. State and date of injury or onset of illness                                                    |  |      |  |                                                                         |  |                             |  |                      |  | 10. Injury       |
| 15. Date and time of first examination or treatment                                                 |  |      |  |                                                                         |  |                             |  |                      |  | 11. Injury       |
| 16. Name and address of physician                                                                   |  |      |  |                                                                         |  |                             |  |                      |  | 12. Injury       |
| 17. Name and address of hospital                                                                    |  |      |  |                                                                         |  |                             |  |                      |  | 13. Injury       |
| 18. Name and address of employer                                                                    |  |      |  |                                                                         |  |                             |  |                      |  | 14. Injury       |
| 19. Name and address of insurance company                                                           |  |      |  |                                                                         |  |                             |  |                      |  | 15. Injury       |
| 20. Name and address of attorney                                                                    |  |      |  |                                                                         |  |                             |  |                      |  | 16. Injury       |
| 21. Name and address of agent                                                                       |  |      |  |                                                                         |  |                             |  |                      |  | 17. Injury       |
| 22. Name and address of agent                                                                       |  |      |  |                                                                         |  |                             |  |                      |  | 18. Injury       |
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| 100. Name and address of agent                                                                      |  |      |  |                                                                         |  |                             |  |                      |  | 96. Injury       |

[illegible]

|                                                                                                                                          |  |                   |  |                                                          |     |                    |         |                                                                                          |  |
|------------------------------------------------------------------------------------------------------------------------------------------|--|-------------------|--|----------------------------------------------------------|-----|--------------------|---------|------------------------------------------------------------------------------------------|--|
| 16. <b>ADDITIONAL COMPLAINTS</b> (Continued July - Use reverse side if more space is required.)                                          |  |                   |  |                                                          |     |                    |         |                                                                                          |  |
| 17. <b>DIAGNOSTIC FINDINGS</b> (Use reverse side if more space is required.)                                                             |  |                   |  |                                                          |     |                    |         |                                                                                          |  |
| A. Physical examination                                                                                                                  |  |                   |  |                                                          |     |                    |         |                                                                                          |  |
| B. Laboratory and diagnostic results (List if more is pending.)                                                                          |  |                   |  |                                                          |     |                    |         |                                                                                          |  |
| 18. <b>EXPOSURES</b> (If occupational illness reports, identify agent and duration of exposure.) (Indicate if toxic substances involved) |  |                   |  |                                                          |     |                    |         | <input type="checkbox"/> Yes <input type="checkbox"/> No                                 |  |
| ICD-9-Cause: _____                                                                                                                       |  |                   |  |                                                          |     |                    |         |                                                                                          |  |
| 19. Are your findings and diagnosis consistent with patient's account of injury or onset of illness?                                     |  |                   |  |                                                          |     |                    |         | <input type="checkbox"/> Yes <input type="checkbox"/> No If "No," please explain: _____  |  |
| 20. Is there any other current condition that contributes or delays patient's recovery?                                                  |  |                   |  |                                                          |     |                    |         | <input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes," please explain: _____ |  |
| 21. <b>TREATMENT RECOMMEND</b> (Use reverse side if more space is required.)                                                             |  |                   |  |                                                          |     |                    |         |                                                                                          |  |
| 22. If further treatment required, specify treatment plan/estimated duration.                                                            |  |                   |  |                                                          |     |                    |         |                                                                                          |  |
| 23. If hospitalized as inpatient, give hospital name and location.                                                                       |  |                   |  |                                                          |     |                    |         |                                                                                          |  |
|                                                                                                                                          |  |                   |  | Date admitted                                            | Mo. | Day                | Yr.     | Referral/Ref by                                                                          |  |
| 24. <b>WORK HISTORY</b> - Is patient able to perform usual work?                                                                         |  |                   |  | <input type="checkbox"/> Yes <input type="checkbox"/> No |     |                    |         |                                                                                          |  |
| If "No," state when patient can return:                                                                                                  |  |                   |  | Regular work                                             | /   | /                  |         |                                                                                          |  |
|                                                                                                                                          |  |                   |  | Modified work                                            | /   | /                  | Specify |                                                                                          |  |
| INSTRUCTIONS: _____                                                                                                                      |  |                   |  |                                                          |     |                    |         |                                                                                          |  |
| Doctor's Signature                                                                                                                       |  | Signature on file |  |                                                          |     | ICD-9-Cause Number |         |                                                                                          |  |
| Doctor's Name and Office                                                                                                                 |  |                   |  |                                                          |     | ICD-9-Cause        |         |                                                                                          |  |

# How To Complete California Doctors First Report Box 16

**Clifford Lane**



## **How To Complete California Doctors First Report Box 16:**

## Unveiling the Magic of Words: A Report on "**How To Complete California Doctors First Report Box 16**"

In a global defined by information and interconnectivity, the enchanting power of words has acquired unparalleled significance. Their power to kindle emotions, provoke contemplation, and ignite transformative change is really awe-inspiring. Enter the realm of "**How To Complete California Doctors First Report Box 16**," a mesmerizing literary masterpiece penned by a distinguished author, guiding readers on a profound journey to unravel the secrets and potential hidden within every word. In this critique, we shall delve to the book is central themes, examine its distinctive writing style, and assess its profound affect the souls of its readers.

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