

U. S. COAST GUARD RESERVE MONTHLY PHYSICIAN REPORT

PRIVACY ACT STATEMENT

In accordance with 5 U.S.C. 522A (e)(3), the following information is provided when supplying personal information to the Coast Guard:

Authority: 37 U.S.C. 204 (g), (h), (i); 37 U.S.C. 206 (a)(3); 5 U.S.C. 301; 44 U.S.C. 3101; 10 U.S.C. 1071-1107; 14 U.S.C. 93(a)(17); 14 U.S.C. 707(d) and 14 U.S.C. 632.

Principle Purpose: To verify member's disability cause by service-connected injury, illness or disease, and the final diagnosis.

Routine Uses: To determine eligibility for disability pay and treatment in a military or civilian treatment center at government expense.

Disclosure: Voluntary. However, failure to provide the requested information may delay payment for incapacitation or delay in final disposition of member's case (Comptroller General's decision #B-185404, 2 August, 1976).

Information contained in this form, including any attachments, may be subject to the provisions of the Privacy Act of 1974 and Health Insurance Portability and Accountability Act (HIPAA) and shall only be reviewed or forwarded to personnel who are authorized AND have a need to know. If you have received this information in error, notify the individual identified so appropriate action may be taken.

SECTION I – MEMBER INFORMATION

(Completed by Reservist – PLEASE TYPE or PRINT CLEARLY)

1a. Last Name	1b. First Name	1c. MI	2. Rank/Rate	3. EMPLID
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4. Military Duties:

5. Civilian Job Description:

SECTION II - PHYSICIAN REPORT

6a. Provider's Name	6b. Provider's Address	6c. Provider's Phone Number
		6d. Provider's Email

7a. Date injury/illness/disease was incurred/aggravated (DD MMM YY): _____

7b. ICD-10 code(s)	7c. Injury/Illness/Disease
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8. For the injury/illness/disease in block 7c. indicate member's ability to perform duties:

8a. Military Duties (Select one):	AFFD	NAFD	AFLD	If AFLD, list limitations/restrictions:
8b. Civilian Duties (Select one):	AFFD	NAFD	AFLD	If AFLD, list limitations/restrictions:

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1a. Last Name	1b. First Name	1c. MI	2. Rank/Rate	3. EMPLID
9. Prognosis (Excellent, Good, Fair, Poor):		10. Expected date or number of weeks until return to AFFD:		
<p>11. Detailed treatment plan (e.g. Intensive physical therapy 2 times per week for 8 weeks):</p> <p>Orthopedic Evaluation estimated date: _____ Medications: _____</p> <p>Physical Therapy _____ times per week for _____ week(s)</p> <p>Imaging Referral (e.g. X-Ray, MRI, CT) type: _____</p> <p>Labs needed: _____ Requires compression wrap/brace: _____</p> <p>Surgery required, expected date: _____ Anticipated recovery: _____</p> <p>Other referral(s) made: _____ Requires immobilization device (brace/cast/garment): _____</p> <p>Additional Treatment:</p>				
12a. Date of this appointment (DD MMM YY):		12b. Date of next appointment (DD MMM YY):		
<p>13. Has a Temporary Limited Duty (TLD) been approved by HSWL SC? Yes No</p> <p>If YES, date TLD approval entered into MRRS: _____ TLD expiration date: _____.</p>				
<p>14. Has a Medical Evaluation Board (MEB) been initiated (MEB is required if the member is not expected to be fit for full duty after 6 months from injury)? Yes No If YES, date MEB date entered into MRRS: _____.</p>				
<p>15. Has MEB been sent (checked-in and accepted) to CG PSC-PSD-de? Yes No</p>				
16. Remarks:				
<p>17. I understand that this information may be used by the member as the basis of a claim against the U.S. Government. I further understand that knowingly and willfully assisting a member in making a false claim or statement is a criminal offense under Federal and State laws which may subject the parties to a substantial fine and/or lengthy imprisonment. _____ Provider's Initials</p>				
18a. Provider's Signature			18b. Date (DD MMM YY)	