Form AR- 3	A Carrier, Self Insured Employer, or Third Party Administrator may print its name and address here.	3
Authority: Ark Code Ann. §11-9-516 and AWCC Rule 27 Revised 1-1-2001		

PHYSICIAN'S REPORT

❑ **First Report** ❑ **Progress Report** ❑ **Final Report** _____

Date of Release From Treatment

AWCC File No.	Carrier Claim No.	Claimant Name (Last, First, MI)	Claimant SS No.

Employer Name	Employer Address	City	State	Zip Code
Carrier Or Self-Insured Name		Mailing Address		

Physician's Report of Injury and Treatment

Brief Description of Accident

Diagnosis/Treatment Rendered

Prognosis/Expected Duration of Treatment

If claimant is suffering from any other disabling condition not due to this accident, specify condition:

NOTE TO COMPLETING PHYSICIAN:
THE BACK SIDE OF THIS FORM MUST ALSO BE COMPLETED, WHERE APPLICABLE.

Temporary Disability

3

The claimant cannot return to work due to his/her work-related injury until after his/her next appointment with me on _____ (date).

The claimant cannot return to work due to his/her work-related injury until _____ (date).

The claimant can return to work on _____ (date) with no restrictions.

The claimant can return to work on _____ (date) with the following temporary restrictions:

- ❑ No standing for more than _____ hours
- ❑ No sitting for more than _____ hours
- ❑ No lifting more than _____ pounds
- ❑ No working more than _____ hours per day
- ❑ Other (specify):

Permanent Disability

- ❑ The claimant has suffered no permanent impairment due to his/her work-related injury.
- ❑ The maximum medical improvement date (end of healing period): _____ (date)
- ❑ The claimant has suffered a permanent impairment rating of _____% to the body as a whole, based on objective and measurable findings such as:
- ❑ The claimant has suffered a permanent impairment rating of _____% to the _____(body part).
- ❑ The claimant has suffered facial or head disfigurement.
- ❑ The claimant has suffered permanent, total disability.

Physician Information

License State	Date of AR Licensure	License Number
Physician's Signature	Physician's Printed or Typewritten Name	Date

Form 3 is approved by the Arkansas Workers' Compensation Commission, P.O. Box 950, Little Rock, Arkansas 72203-0950, for use by providers to report the status of a patient's treatment. Form 3 should be sent by the medical provider to the company handling the workers' compensation case for the employer.