Tennessee Bureau of Workers' Compensation
220 French Landing Drive, I-B
Nashville, TN 37243-1002
800-332-2667

FORM C-30A

FINAL MEDICAL REPORT

This Report is to be completed by the treating physician and provided to the adjuster or insurance carrier within *21 days* of the date the injured worker has reached Maximum Medical Improvement (MMI).

STATE FILE # _____ DATE OF INJURY _____ DATE OF MMI _____

PATIENT NAME _____ SSN _____

EMPLOYER _____

INSURANCE CARRIER _____

IN YOUR MEDICAL OPINION,

ON WHAT DATE WAS THE PATIENT ABLE TO RETURN TO WORK,
WITH RESTRICTIONS? _____

WITHOUT RESTRICTIONS? _____

IF APPLICABLE, WHAT WERE THE DATES WHEN THE PATIENT WAS **UNABLE** TO WORK?
FROM_____ TO_____

DO YOU ANTICIPATE THE NEED FOR FUTURE MEDICAL TREATMENT FOR THIS INJURY?
◯ YES ◯ NO

DID THE INJURY RESULT IN PERMANENT IMPAIRMENT? ◯ YES ◯ NO

IF YES, COMPLETE THE FOLLOWING:
(USE THE 6th EDITION OF AMA GUIDES® TO DETERMINE THE IMPAIRMENT RATING)

FOR INJURIES ON OR AFTER JULY 1, 2014

_____ PERCENTAGE TO THE BODY AS A WHOLE

FOR INJURIES PRIOR TO JULY 1, 2014

_____ PERCENTAGE to _____ BODY PART

◯ LEFT ◯ RIGHT

_____ PERCENTAGE to _____ BODY PART

◯ LEFT ◯ RIGHT

_____ PERCENTAGE to _____ BODY PART

◯ LEFT ◯ RIGHT

This Report must be completed, signed and dated by the treating physician only.

PHYSICIAN SIGNATURE_____ DATE_____

PHYSICIAN NAME (Printed) _____ MED LICENSE # _____STATE _____