WCB Workers Compensation Board of Manitoba

Please FAX this form IMMEDIATELY
Winnipeg: 954-4999
Toll free: 1-877-872-3804
333 Broadway • Winnipeg R3C 4W3
Telephone 954-4922 • Toll free 1-800-362-3340

DOCTOR FIRST REPORT

Claim No. | 4

Worker Information

Last Name	First Name	Address			
City	Province	Postal Code	Telephone No. ( )		
Gender	Height	Weight	Date of Birth DD / MM / YYYY	PHIN _ _ _ - _ _ _ - _ _ _	Job Title

Employer Information

Name	Address	
City	Province	Postal Code

Injury Details

Date of Incident DD / MM / YYYY	Area of Injury
Worker's description of incident or injury	

Examination Findings & Diagnosis

Date of Examination DD / MM / YYYY	ICD Code	Diagnosis
Subjective Complaints		
Objective Findings (include ROM, muscle testing & neurological status)		
Describe any pre-existing condition that may affect recovery		

Tests performed (e.g. X-ray, CT Scan, MRI, etc.) Attach results	Location	Date DD / MM / YYYY

Treatment Plan

Description (e.g. physio, medication and dosages)	Date of Next Visit DD / MM / YYYY

Work Capabilities

Will Worker be disabled from work beyond the date of incident as a result of the injury? ☐ yes ☐ no	When can Worker return to regular duties? Date DD / MM / YYYY ☐ Unknown at time of examination
Is Worker capable of alternate or modified work? ☐ yes ☐ no If yes, outline restrictions:	Duration of restrictions: _____ weeks

Physician Information

Physician Name	Telephone No. ( )	Fax No. ( )	
Address	Physician Signature		Date DD / MM / YYYY
City / Province / Postal Code			

WCB 4036

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