Medical Information Form

Your physician or mental health provider must complete the form to confirm your inability to work as a direct result of the incident. Your provider should return the form directly to our office.

Patient's Name: _____ Patient's DOB: _____

1. Date of injury: _____
2. Was this a crime-related injury? Yes ☐ No ☐ Unknown ☐
3. Was this a work-related injury? Yes ☐ No ☐ Unknown ☐
4. Date the patient was first seen by you in relation to the injury: _____
5. Please describe the injuries:

   _____
   _____
   _____

   Diagnosis:

   _____
   _____

   Prognosis:

   _____
   _____
   _____
   _____

6. Date of disability: From _____ to _____

   Comments or concerns:

   _____
   _____
   _____

SECTION MUST BY COMPLETED BY PROVIDER

Name of Provider Completing Form (print): _____

Address: _____

Phone No. (_____)_____

Signature: _____ Date: _____

Please return form to

Violent Crimes Compensation Board
PO Box 110230
Juneau, AK 99811
Fax: 907.465.2379
Email: doa.vccb@alaska.gov