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 the patient was first seen by you in relation to the crime: ____________________________________
2. Do the injuries appear to be a direct result of the crime, if applicable? Yes ☐ No ☐ Unknown ☐
3. Please describe the injuries that occurred as a result of the crime, if any:

   ____
   ____
   ____

4. Please describe any permanent disability or disfigurement the patient sustained as a result of the crime, if any:

   ____
   ____
   ____

5. Please describe any emotional trauma as a result of the crime:

   ____
   ____
   ____

6. Check all that applies in accordance to the patient's physical and/or emotional ability:

   ☐ May resume work immediately without restrictions
   ☐ May resume work immediately with the following restrictions: ________________________
   ____
   ☐ Patient may return to work at full capacity on (date): _________________________________
   ☐ Patient may return to work at partial capacity on (date): ______________________________
   ☐ Patient has a return appointment on (date): ____

7. Comments:

   ____
   ____
   ____

Name of Provider Completing Form (print): ____

Address: ____

Phone No. (______)______________________

Signature: ____ Date: __________________________

Please return this form to: Violent Crimes Compensation Board
P.O. Box 110230
Juneau, AK 99811