PROTECTIVE INSURANCE COMPANY
Work Accident Claims Department
111 Congressional Blvd., Suite 500
Carmel, Indiana 46032
1-800-231-6024

GROUP INDEPENDENT CONTRACTOR WORK ACCIDENT INSURANCE

DOCTOR'S REPORT

Instruction: Please complete, sign and return this report to Protective as soon as possible. Receipt of benefits by your patient and payment of your charges may be dependent upon prompt completion of this form.

1. Patient's Name and Address (No., Street, County, State, Zip)	2. Social Sec. No. - -	3. Birthdate / / (Month, Day, Year)	4. DO NOT COMPLETE THIS PART Group Sponsor: Group Master Policy Number:

5. Date of Initial Consultation / / (Month, Day, Year)	6. Describe in detail Patient's condition and your diagnosis. A. CONDITION B. PRIMARY DIAGNOSIS C. SECONDARY DIAGNOSIS (Include Complications) D. SUBJECTIVE SYMPTOMS
7. Reason for Patient's Condition (check one) ____ Accidental ____ Disease ____ Illness ____ Other (Explain)	

8. If condition was the result of an accident, please indicate how the patient described the accident occurred and the date the accident occurred.

9. Are there any other contributing causes to Patient's condition (circle one) YES NO If yes, explain.

10. Have you treated or consulted the Patient for this condition previously? (circle one) Yes No If no, skip to question 13	11. Date first previously treated or consulted for this condition / / (Month, Day, Year)	12. Date last treated or consulted for this condition previously / / (Month, Day, Year)	13. Has the patient aggravated a pre-existing condition? (circle one) Yes No

14. Explain treatment being provided by you. (Include surgery, medications, etc.)

15. Was Patient treated for present condition by anyone else? (circle one) YES NO If yes, state by whom (Name, No., Street, City, County, State, Zip)

16. Was Patient hospitalized? (circle one) Yes No	17. Date of admission / / (Month, Day, Year)	18. Date of discharge / / (Month, Day, Year)	19. Is further hospitalization needed? (circle one) Yes No

(over)

21. Is further treatment needed? (circle one) YES NO If yes, explain and state for how long

22. Was Patient disabled due to accident? (circle one) Yes No	23. Date Disability Began / / (Month, Day, Year)	24. Is Patient still disabled? (circle one) Yes No	25. Date Disability Ended / / (Month, Day, Year)

26. When will Patient be able to return to his Pre-Accident work?	27. When will Patient be able to return to any type of work?	28. Is Patient a suitable candidate for vocational rehabilitation? (circle one) Yes No

29. What is your prognosis for Patient? (Include comments on further treatment required and the likely duration of disability, if any.)

30. Remarks:

Please Print	Name of Attending Doctor	Phone

Street Address	City or Town	State	Zip

Signature Date

Protective Insurance Company would like to thank you for your cooperation in completing this form. Should there be any problem with the payment of your charges please contact us directly at 1-800-231-6024.

Protective Insurance Company