DEPARTMENT OF HOMELAND SECURITY

U.S. Coast Guard

MONTHLY PHYSICIAN REPORT

PRIVACY ACT STATEMENT

In accordance with 5 U.S.C. 522A (e)(3), the following information is provided when supplying personal information to the Coast Guard:

Authority: 37 U.S.C. 204 (g), (h), (i); 37 U.S.C. 206 (a)(3); 5 U.S.C. 301; 44 U.S.C. 3101; 10 U.S.C. 1071-1107; 14 U.S.C. 93(a)(17); 14 U.S.C 707(d) and 14 U.S.C. 632.

Principle Purpose: To verify member's medical status is caused by service-connected injury, illness or disease, and the final diagnosis.

Routine Uses: To determine eligibility for disability pay and treatment in a military or civilian treatment center at government expense.

Disclosure: Voluntary. However, failure to provide the requested information may delay payment for incapacitation or delay in final disposition of member's case (Comptroller General's decision #B-185404, 2 August, 1976).

Information contained in this form, including any attachments, may be subject to the provisions of the Privacy Act of 1974 and Health Insurance Portability and Accountability Act (HIPAA) and shall only be reviewed or forwarded to personnel who are authorized AND have a need to know. If you have received this information in error, notify the individual identified so appropriate action may be taken.

SECTION I - MEMBER INFORMATION *(Completed by Member - PLEASE PRINT)*

1a. Last Name	1b. First Name	1c. MI	2. Rate/Rank	3. EMPLID

4. Military Duties

5. Civilian Duties

SECTION II - PHYSICAN REPORT *(Completed by Medical Provider - PLEASE PRINT)*

6a. Provider's Name	6b. Provider's Address	6c. Provider's Phone Number
		6d. Provider's Email

7a. Date injury/illness/disease was incurred/aggravated/first diagnosed:

7b. ICD-10 code(s)	7c. Injury/Illness/Disease

8. For the injury/illness/disease in block 7c., indicate member's ability to perform duties:

8a. Military Duties *(select one)*:	AFFD ☐ NAFD ☐ AFLD ☐	If AFLD, list limitations/restrictions
8b. Civilian Duties *(select one)*:	AFFD ☐ NAFD ☐ AFLD ☐	If AFLD, list limitations/restrictions

9. Prognosis *(select one)*: Excellent ☐ Good ☐ Fair ☐ Poor ☐	10. Expected date or number of weeks until return to AFFD

11. Based upon my examination, I believe the condition(s) evaluated here are: Line of Duty ☐ Not Line of Duty ☐ Misconduct ☐
(Explain decision in block 17).

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1a. Last Name	1b. First Name	1c. MI	2. Rate/Rank	3. EMPLID

12. Detailed treatment plan *(e.g. Intensive physical therapy 2 times per week for 8 weeks)*:

Orthopedic Evaluation *(estimated date)*:	Medications
Physical Therapy: _____ times per week for _____ week(s)	
Imaging Referral *(e.g. X-Ray, MRI, CT)* type: _____	
Labs needed: _____	Requires compression wrap/brace: ☐ Yes ☐ No
Surgery required: ☐ Yes ☐ No Expected Date:	Anticipated recovery:
Other referral(s) made: _____	Requires immobilization device *(brace/cast/garment)*: ☐ Yes ☐ No

Additional Treatment

13a. Date of this appointment	13b. Date of next appointment

14. Has a Temporary Limited Duty (TLD) been approved by HSWL SC? ☐ Yes ☐ No

If Yes, date TLD approval entered into MRRS: TLD expiration date:

15. Has a Medical Evaluation Board (MEB) been initiated? *(MEB is required if the member is not expected to be fit for full duty after 6 months from injury.)* ☐ Yes ☐ No

If Yes, has MEB date been entered into MRRS? ☐ Yes ☐ No

16. Has MEB been sent *(checked in and accepted)* to CG PSC-PSD-de? ☐ Yes ☐ No

17. Remarks

18. I understand that this information may be used by the member as the basis of a claim against the U.S. Government. I further understand that knowingly and willfully assisting a member in making a false claim or statement is a criminal offense under Federal and State laws which may subject the parties to a substantial fine and/or lengthy imprisonment.

Provider's Initials: _____

19a. Date	19b. Provider's Signature