

**State of California**  
**Division of Workers' Compensation**  
**Treating Physician's Progress Report (DWC Form PR-2)**

**Date of Report:**  
**Provider Name:**

Attachments:  Request for Authorization  Other  
Rendering Provider is:  Primary Treating Physician (PTP)  
 Secondary Treating Physician

**Section A: Routing**

1. Send document to those listed below (as applicable).

Claims Administrator Name and Address:

Patient Name and Claim Information

Patient Name:  
Date of Birth:  
Date of Injury:  
Employer:  
Claim Number:

Phone Number:  
Fax Number:

Provider Name and Information

Provider Name:  
Practice Name:  
Address:  
City/State/Zip Code:  
Phone Number:  
Fax Number:

Primary Treating Physician Name and Address:

Phone Number:  
Fax Number:

Provider Specialty:  
Provider State License Number:  
National Provider ID Number:  
Name of Medical Provider Network (MPN)  
(if available):

Optional Addressee:

Phone Number:  
Fax Number:

2. Check the boxes that indicate why you are submitting a report at this time. Check all that apply.

<input type="checkbox"/> Periodic Report	<input type="checkbox"/> Change in Treatment Plan	<input type="checkbox"/> Release from Care
<input type="checkbox"/> Change in Work Status	<input type="checkbox"/> Request for Authorization	<input type="checkbox"/> Transfer Care To:
<input type="checkbox"/> Response to Request for Information	<input type="checkbox"/> Change in Patient's Condition	<input type="checkbox"/> Other:

3. Sections included in this report:

- Section B: Evaluation and Management Worksheet
- Section C: Work Status
- Other

I declare under penalty of perjury that this report is true and correct to the best of my knowledge and that I have not violated Labor Code section 139.3.

Provider Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Executed at: \_\_\_\_\_

**Section B: Evaluation and Management Worksheet**  
Contains Private Healthcare Information

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1. Chief Complaint(s) and Interval History (Subjective Complaints):

2. Physical Examination (Objective):

3. Other Information Reviewed (includes consultations, records, laboratory, radiology, and diagnostic testing):

4. Assessment/Diagnosis (include co-morbidities and complications):

Primary Diagnosis: _____	ICD-9 _____
Secondary Diagnosis: _____	ICD-9 _____
Additional Diagnosis: _____	ICD-9 _____
Additional Diagnosis: _____	ICD-9 _____

5. Discussion (indicate assessment in this space):

6. Plan:

If physician is requesting authorization for treatment, indicate the treatment(s), what is to be treated, justification, and reference to treatment guidelines. Indicate whether any prescription for medication or supplies must be dispensed as written. This information must be indicated in the Request for Authorization for Medical Treatment (DWC Form RFA) to specify requested treatment.

- Continue same treatment plan (see prior reports).
- Change in treatment plan – see attached Request for Authorization for Medical Treatment (DWC Form RFA).
- Discharge from care.
- Dispense prescription as written.

7. Length of Visit

If more than 50% of visit time involves counseling and/or coordination of care, then time may determine level of E&M services. Total face-to-face time (min.): \_\_\_\_\_ Counseling/coordination of care time (min.): \_\_\_\_\_

Patient Name:  
Provider Name:  
Date of Visit:

### Section C: Work Status

Employers may only receive Section A (Routing Document) and Section C (Work Status) as other sections contain private healthcare information.

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#### 1. The Patient has been instructed to:

Date: \_\_\_\_\_  
Date: \_\_\_\_\_

- Return to full duty without restrictions.
- Return to work with the following work restrictions:  
(List all specific, functional restrictions, i.e., standing, sitting, bending, lifting, etc.)

Date: \_\_\_\_\_  
to  
Date: \_\_\_\_\_

- Patient is unable to return to work in any capacity for the indicated period.  
State reason:

#### 2. Patient Status:

Date: \_\_\_\_\_  
Date: \_\_\_\_\_  
Date: \_\_\_\_\_  
Date: \_\_\_\_\_

- Anticipate date of return to full duty with no limitations or restrictions.
- Anticipated date of maximum medical improvement and permanent restrictions.
- Date of next visit.
- Date discharged from care.

