WORKERS' COMPENSATION MEDICAL SUMMARY

This form must accompany Workers' Compensation Claims and Petitions (See 8AAC 45.052).

1. A copy of the Summary (and any attachments) MUST be served on the adjuster or attorney of record.
2. Send the original of the Summary and copies of the attachments to the Alaska Workers' Compensation Board (addresses listed below).

Employee's Name (Last, First, Middle Initial)	AWCB Case Number	Date of Injury
Employer	Employee's Social Security Number	

TO: (List all persons to whom you are mailing this summary. Include addresses.)

☐ Please mark an "X" here if you have no medical records in your possession of this date.

List Medical Records in Chronological Order			Brief Description of Medial Record (option but please identify most important records
1. Report Date	Doctor/Provider	Report Type	
2. Report Date	Doctor/Provider	Report Type	
3. Report Date	Doctor/Provider	Report Type	
4. Report Date	Doctor/Provider	Report Type	
5. Report Date	Doctor/Provider	Report Type	
6. Report Date	Doctor/Provider	Report Type	
7. Report Date	Doctor/Provider	Report Type	
8. Report Date	Doctor/Provider	Report Type	
9. Report Date	Doctor/Provider	Report Type	
10. Report Date	Doctor/Provider	Report Type	
11. Report Date	Doctor/Provider	Report Type	
12. Report Date	Doctor/Provider	Report Type	
13. Report Date	Doctor/Provider	Report Type	
14. Report Date	Doctor/Provider	Report Type	
15. Report Date	Doctor/Provider	Report Type	

Proof of Service: I certify that I mailed a copy of this summary to the persons and addresses listed above:

Name of Person Who Prepared This Summary (Print or Type)

Name of Person Certifying Service (Print or Type)

Signature

Date Mailed

REPORT TYPE CODE: Chart Notes =C, Discharge Summary = D, Hospital Records =H, Initial Report = I, Narrative Report =N, Operative Report = O, Physical Examination & History = E, Progress Report = P, X-Ray Report = X, Miscellaneous = M, Second Independent Medical Evaluation = SIME, Employer Independent Medical Evaluation = EIME

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