# 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 |
|---|---|---|
| Doe, John | 201799999 | 1/01/2017 |
| **Employer** | **Employee's Social Security Number** | |
| Acme Corporation | 123-45-6789 | |

TO: (List all persons to whom you are mailing this summary. Include addresses.)
Big Profit Insurance Company, 3300 Denali St Ste 1200, Anchorage AK 99501

☐ 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<br>Apr 12, 2017 | Doctor/Provider<br>Alaska Spine Institute | Report Type<br>O | Bilateral L4-5 ESI, 1 page |
| 2. Report Date<br>Apr 12, 2017 | Doctor/Provider<br>Alaska Spine Institute | Report Type<br>C | 1 page |
| 3. Report Date<br>Apr 13, 2017 | Doctor/Provider<br>Alaska Spine Institute | Report Type<br>C | 1 page |
| 4. Report Date<br>Sep 30, 2017 | Doctor/Provider<br>Alaska Spine Institute | Report Type<br>C | 1 page |
| 5. Report Date<br>Nov 14, 2017 | Doctor/Provider<br>Swanson | Report Type<br>EIME | 9 pages |
| 6. Report Date<br>Nov 20, 2017 | Doctor/Provider<br>ASI | Report Type<br>C | 1 page |
| 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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Alaska Workers' Compensation Board
P.O. Box 115512
Juneau, AK 99811-5512
(907) 465-2790

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