State of Connecticut
Workers' Compensation Commission

Please TYPE or PRINT IN INK

Rev. 9-3-2010

42

WCC File # _____

Insurer # _____

Date filed in District

(for WCC use only)

Physician's Permanent Impairment Evaluation

The Form 42 should be mailed to ALL parties (employee, insurer, attorneys).

EMPLOYEE

Name _____

D.O.B. *(required)* _____

Address _____

City/Town _____ State _____

Zip Code _____ Tel.# _____

EMPLOYER

Name _____

INJURY

Date of Injury _____

City/Town of Injury _____

State _____ Zip Code _____

EVALUATION — IMPORTANT! Use a separate Form 42 for EACH body part!

Connecticut Statutes do NOT recognize whole person ratings [Section 31-308(b)].

Body Part _____

LIMB is ..... ❑ LEFT ..... ❑ RIGHT

HAND, ARM, or THUMB is ..... ❑ MASTER ..... ❑ MINOR

EYE is ..... ❑ LEFT * ..... ❑ RIGHT *

* Indicate: ❑ complete and permanent loss of sight

❑ reduction of sight to one-tenth (1/10) or less of normal vision

Which standards were utilized in your evaluation (AMA Edition # or Other Source):

_____

Percentage of Permanent Loss (or Loss of Use) _____

Maximum Medical Improvement Exam Date _____

Does the patient have a work capacity? ..... ❑ YES ..... ❑ NO

If the patient DOES have a work capacity, please list any physical restriction(s):

_____

_____

_____

_____

CONNECTICUT-LICENSED PHYSICIAN — SIGNATURE

Name _____ Tel. # _____

Address _____

City/Town _____ State _____ Zip Code _____

Signature of Connecticut-Licensed Physician _____ Date _____

Print Name of Connecticut-Licensed Physician _____