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)  Click or tap here to enter text. | | | | 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 NEW medical records in your possession of this date. | | | | | |
| List Medical Records in Chronological Order | | | Brief Description of Medical 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) | | | 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 | | |
| Signature | | |
| Date Mailed | | |

Alaska Department of Labor & Workforce Development Alaska Workers' Compensation Board

P.O. Box 115512

Juneau, AK 99811-5512

(907) 465-2790

Form 07-6103 (Rev 8/2023)

Alaska Department of Labor & Workforce Development Alaska Department of Labor & Workforce Development Alaska Workers' Compensation Board Alaska Workers' Compensation Board

3301 Eagle Street, Suite 304 675 Seventh Avenue, Station K

Anchorage, AK 99503 Fairbanks, AK 99701-4531

(907) 269-4980 (907) 451-2889