WORK LOSS - PHYSICIAN'S REPORT

NORTH DAKOTA DEPARTMENT OF CORRECTIONS AND REHABILITATION
SFN 60497 (Rev. 06-2018)

Email To:
docrcompensation@nd.gov

Crime Victims Compensation
PO Box 1898
Bismarck ND 58502-1898
(701) 328-6195 / 800-445-2322

An application for assistance has been filed with our office for the patient listed below. Please complete this form and fax or email at your earliest convenience.

***FORM MUST BE COMPLETED BY A MEDICAL PROVIDER WHO TREATED YOU FOR YOUR CRIME INJURIES.**

Name of Injured Patient	DOB	Crime Victims Compensation Form Number

Date the Patient was First Seen ____/____/____	*Date of Crime Injury (must be completed)

Diagnosis

Briefly Describe Extent and Location of Injuries

Did the patient sustain any disability? ☐ No ☐ Yes	If yes, is the disability solely a result of this injury? ☐ No ☐ Yes

Please Explain

*Patient will be Unable to Work from ____/____/____ through ____/____/____	Has the patient been discharged from your care? ☐ No ☐ Yes

Has payment been filed with any of the following?

Medicaid ☐ No ☐ Yes Policy Number			Workers' Compensation ☐ No ☐ Yes
Medicare ☐ No ☐ Yes Policy Number			
Other Insurance or Program ☐ No ☐ Yes	Name of Company or Agency		
Address	City	State	Zip Code

Type or Print Physician's Name			Telephone Number ( )
Signature of Physician			Date
Address of Physician	City	State	Zip Code