MEDICAL REPORT ON INDUSTRIAL INJURY

*Provision of your Social Security Number (SSN) is voluntary. Failure to provide it may result in an information processing delay.

The Department of Workforce Development (DWD) administers the Worker's Compensation Act, Chapter 102 Wis. Stats. The purpose of this form is to assist with the procurement of information related to or required by Chapter 102. Completion of this form is voluntary and failure to complete said form may result in a delay in the administration of Chapter 102.   DWD may use the personally identifiable information (PII) it obtains from you on this form for purposes other than those for which it is being collected.

PATIENT	WC Claim Number	Employee Name	
	Employee Social Security Number*	Employee Address	
	Injury Date	Employer Name	Insurance Company

HISTORY	History as described by patient

DIAGNOSIS (Please be as detailed as possible)	

PERMANENT DISABILITY
(Describe permanent elements of disability, such as limitation of motion, pain, weakness, etc., and describe effect on working ability.)

What amputation present?		Comparative x-rays taken? ☐ Yes ☐ No		Stump: ☐ hardy or ☐ tender
Has permanent disability resulted? ☐ Yes ☐ No	Date of Last Exam	Has healing period ended? ☐ Yes ☐ No		Patient discharged? ☐ Yes ☐ No
Description of permanent disability (Record finger motion losses on reverse.)				
Was surgery performed as a result of accident? ☐ Yes ☐ No If Yes, state type of surgery:				
If healing has not ended, what is minimum permanent disability expected?				

PRIOR DISABILITY	What previous disability?

PROGNOSIS	Prognosis:
	Date injured was or will be able to return to a limited type of work: State any limitations:
	Date injured was or will be able to return to full-time work subject only to permanent limitations:
	What further treatment should be given?

Additional comments, if any:

Date	City	Physician or Chiropractor Signature (in own writing)
	Phone Number ( ) -	Typed or Printed Name

WKC-16 (R. 09/2024)

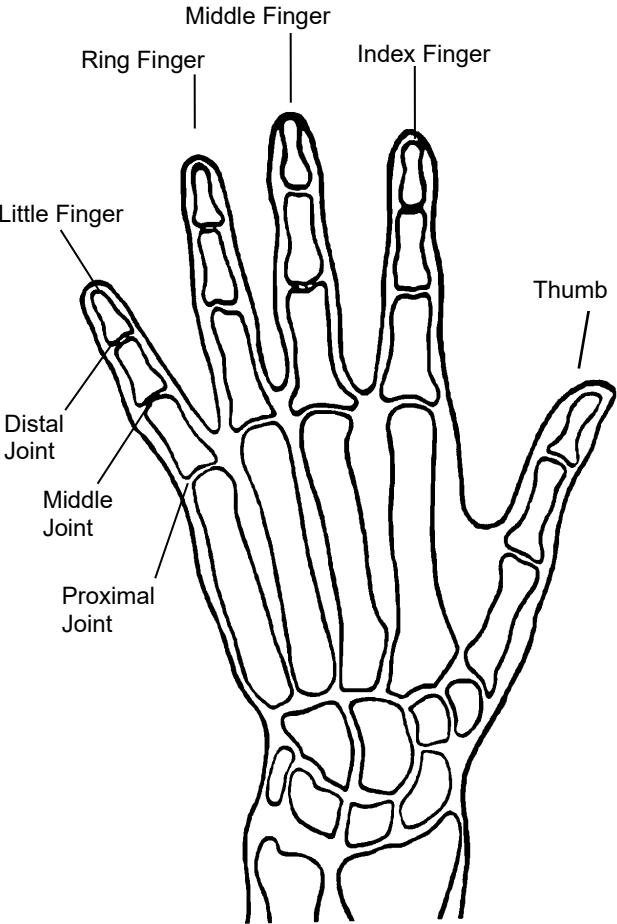| Employee Name	Employee Social Security Number

Instructions for finger injuries

Please use statutory terms in referring to fingers, such as thumbs, index, middle, ring, and little fingers, and distal, middle, and proximal joints. Where there is limitation of motion, list separately the normal range of motion in degrees, the "degrees" loss of flexion, and the "degrees" loss of extension for each joint of each finger. The Worker's Compensation Division will evaluate the loss of use due to loss of motion of the fingers.

Where there are other elements of disability of the fingers, such as deformity, weakness, pain, or lack of endurance, give your opinion on the percentage loss of use as compared to amputation for such elements of disability and specify the joint at which such loss is estimated.

Digit	Joint	Angle Ext/Flex	Normal Range of Motion	Degrees Loss Extension	Degrees Loss Flexion	Estimate % loss of use for additional factors at joint involved and reason for additional allowance
Thumb	Dist					
	Prox					
Index	Dist					
	Mid					
	Prox					
Mid	Dist					
	Mid					
	Prox					
Ring	Dist					
	Mid					
	Prox					
Little	Dist					
	Mid					
	Prox					

CIRCLE HAND INVOLVED: Right   Left

DOMINANT HAND: Right   Left

Ring Finger
Middle Finger
Index Finger
Little Finger
Thumb
Distal Joint
Middle Joint
Proximal Joint

See DWD 80.32 & 80.33 for guides to evaluation for amputations, restrictions of motion, ankylosis, sensory loss, and surgical results for disability to the hip, knee, ankle, toes, shoulder, elbow, wrist, fingers and back.

If fingertip amputation is present, submit comparative x-rays or a statement indicating whether the bone loss was less than one-third, between one-third and two-thirds, or more than two-thirds of the distal phalanx.

If amputation is below the distal joint, submit comparative x-rays.