

FPDR



Bureau of Fire and Police Disability and Retirement

1800 SW First Avenue, Suite 450, Portland, OR 97201
503-823-6823; FAX – 503-823-5166; B236/450



ATTENDING PHYSICIAN FIRST REPORT (APR)

MEMBER REPORT

Fire Police

Member's Home Address:

Member's Legal Name:

Telephone(s):

Home: _____ Mobile _____ Work: _____

Date of Injury: _____

New Injury Recurrence (Related to a prior injury)

1st Medical Treatment Date: _____

Brief Description:

APPLICANT'S STATEMENT: I hereby affirm the above information is true and apply for disability benefits. When signed, this report become notice of claim and **authorizes medical providers and other custodians of claim records to release relevant medical records.**

Signature _____

Date _____

PHYSICIAN REPORT

MEDICAL PROVIDERS: This report is *confidential*, for release only to the Bureau of Fire and Police Disability and Retirement. Please FAX a copy of this form to FPDR at 503-823-5166 and mail the original to FPDR. FPDR members are not covered by Oregon Workers' Compensation. This form should be used in lieu of Form 827.

PHYSICIAN'S FINDINGS

(Please Print – All items MUST be completed)

FPDR DATE STAMP

Subjective Findings:

Objective Findings:

Assessment/Diagnosis:

Treatment Plan (frequency and duration) – *If time loss is authorized, complete WSR:*

Note: FPDR has contracted with Kaiser On-The-Job and CareMark Comp MCO (Managed HealthCare NW)

NEXT APPOINTMENT DATE: _____ MEDICALLY STATIONARY AS OF (DATE) _____

Attending Physician (PRINTED NAME) with Professional Designation

Telephone

Attending Physician (SIGNATURE)

Date