Physician's Permanent Impairment Evaluation

Mashantucket Pequot Tribal Nation
Workers' Compensation Commission
P.O. Box 3060
Mashantucket, CT 06338-3060
Phone (860)396-2424 Fax (860)396-2060
MPTNWCC@mptn-nsn.gov

This form should be mailed to ALL parties (employee, insurer, attorneys).

Employer Information (check one)

☐ Mashantucket Pequot Tribal Nation ☐ Mashantucket Pequot Gaming Enterprise

Injured Worker Information

Name: _____

D.O.B.: _____ Telephone: _____ Badge#: _____
Month Day Year

Address: _____

_____
City/Town State Zip Code

Injury Information

Date of Injury: _____ Claim #: _____
Month Day Year

Nature of Injury: _____ Occupational Injury ☐ or Repetitive Trauma ☐

Evaluation

IMPORTANT – Use a separate FORM for EACH body part!

Body Part*: _____

Percentage of Permanent Loss (or Loss of Use): 0.00%

Maximum Medical Improvement Date: _____
Month Day Year

Which standards were used in your evaluation? **(AMA Edition # or Other Source)** _____

*Indicate: complete and permanent loss of sight ☐ reduction of sight to (1/10) or less of normal vision ☐

Licensed Physician - Signature

Name: _____ Telephone: _____
(print)

Address: _____

_____
City/Town State Zip Code

Signature: _____ Date: _____
(Licensed Physician) Month Date Year