Saskatchewan Workers' Compensation Board
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TXD

Click on any field to start editing.

Reset Form

WCB claim number: _____

Worker's name: _____

Clinic name: _____ Clinic number: _____ Care provider number: _____ Phone: _____ Fax: _____ Care provider's name, address, postal code	Provincial Health Number: _____ Date of birth: (MM/DD/YYYY) Phone: _____ Employer name: _____ Worker's name, address, postal code

Injury

1. Date of examination: _____ (MM/DD/YYYY) 2. Date of final treatment: _____ (MM/DD/YYYY)

3. Diagnosis:

4. Functional status on discharge (related to work duties):

5. Outcome code:

- ☐ Code 1 - Discharged without restrictions - return to work
- ☐ Code 2 - Discharged without restrictions - did not return to work
- ☐ Code 3 - Returned to work on a graduated program
- ☐ Code 4 - Discharged with restrictions - return to work
- ☐ Code 5 - Discharged with restrictions - did not return to work
- ☐ Code 6 - Did not complete program. State reason program was not completed:

6. Total number of appointments attended and dates of appointments:

7. Dates absent:

Signature: Please sign form before mailing/faxing. Date: _____ Copy to: _____

When writing to the WCB, please print name and claim or firm number.