

JAN 99

**U.S. DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF PRISONS**

INMATE CLAIM FOR COMPENSATION RESULTING FROM WORK INJURY

(To be filed forty five(45) days prior to claimant's release from institutional confinement for transfer to a Community Treatment Center.)

Institution		Date of Claim	
1. Inmate Name		2. DOB	3. Sex
4. Register number		5. Date received at institution	
6. Sentence	7. Sentence will expire	8. Offense	
9. Date Inmate will leave institution		10. <input type="checkbox"/> MR	
11. If release will be under supervision, indicate location of applicable U.S. Probation Office		<input type="checkbox"/> Parole	
		<input type="checkbox"/> Expiration	
12. If going to a CTC prior to release, give name and address of CTC		<input type="checkbox"/> Detainer	
		<input type="checkbox"/> CTC	
13. Intended release address		<input type="checkbox"/> Deportation	
14. Date of injury		15. Description of injury	
16. Institution and work area where injury occurred			
17. Assigned work being done when injury occurred			
18. Cause of injury			
19. <input type="checkbox"/> Yes <input type="checkbox"/> No In your opinion, is this an original injury		<input type="checkbox"/> Yes <input type="checkbox"/> No Aggravation of a pre-existing condition	
20. Do you feel further medical treatment will be necessary after release <input type="checkbox"/> Yes <input type="checkbox"/> No			
The above injury was sustained by me while in federal confinement and occurred during the performance of my work assignment. Injury was not due to willful misconduct on my part or due to my intention to bring about injury or death to myself or others.			
I understand that compensation may be granted only if there is an existing physical impairment due to the claimed injury. I believe I have sustained such a physical impairment due to the claimed injury and every statement set forth above is true to the best of my knowledge and belief.			
Signature of Claimant			Date

PHYSICIAN'S MEDICAL EVALUATION FOR COMPENSATION CLAIM

TO BE COMPLETED BY SAFETY MANAGER

Name of inmate

Register No.

Date will leave institution

Date of injury which compensation is claimed

TO BE COMPLETED BY EXAMINING PHYSICIAN (Please Type or Print Legibly)

(NOTE: Address all claimed conditions referred to in No. 15 on the reverse side of this claim, using attachments if necessary. Examination should also be entered in patient's medical record, giving specifics as to degree of motion, sensory deficit, etc)

1. If claimant was hospitalized as a result of the claimed accident/injury or occupational illness:

Date admitted to hospital

Date released from hospital

2. Date of this exam

3. ___ Yes ___ No Does this exam disclose impairment

4. If yes, in your opinion is the impairment the result of the above injury allegedly sustained while performing a work assignment

5. Indicate by a check mark whether disclosed work related impairment is: ___ Temporary ___ Permanent ___ N/A

5A. If temporary (not medically stabilized), indicate percentage of impairment to body as a whole _____ %; for period from _____ (Date) to _____ (Date)

5B. If the disclosed work related impairment is permanent and maximum medical benefits have been reached, or if the percentage of permanent impairment can be determined at this time despite the fact that the condition is not necessarily stabilized, show percentage of impairment _____ %; related to the _____ (Finger, Toe, Eye, Whole Person, Etc.)

6. If the disclosed work related impairment is a result of an aggravation of a pre-existing condition which occurred prior to incarceration, or other incident unrelated to claimed injury, estimate the percentage of impairment which you feel was caused by the aggravation _____ %; pre-existing; _____ %; total _____ %

7. Indicate pages and tables of the AMA "Guides to Evaluation of Permanent Impairment", which were used in determining percentage of impairment

8. What future treatment do you recommend if any

9. Submit photographs if applicable (to be provided by safety manager)

10. Remarks (use attachments if necessary)

Signature of Physician

Date

Address