

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)



July 2014

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)
- Unknown

1<sup>st</sup> Medical Treatment Date: \_\_\_\_\_

Brief Description:

**APPLICANT'S STATEMENT:** I hereby affirm the above information is true. When signed, this report **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:*

*For Service-Connected Injuries & Occupational Disabilities, 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  
(MD, DO or **DPM**)

Telephone

Attending Physician (SIGNATURE)

Date