MARSHALL ISLANDS WORKERS' COMPENSATION ADMINISTRATION

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FORM WCP - 602
(Schedule 20)

ATTENDING PHYSICIAN'S RECOMMENDATION FOR PERMANENT TOTAL DISABILITY BENEFITS

This form must be attached to the employee's application for permanent total disability benefits before it is submitted to the WCA.

To : WCA Administrator

I have personally attended to the medical examination and treatment of injuries sustained by ____________________________. Based on the current medical condition of the patient and after carefully reviewing the results of the diagnostics tests conducted, I am of the opinion that the injury(ies) that the employee sustained will result to permanent total disability.

1 Brief history of injury or illness as described by the injured worker or witness	
2 Was there any history or evidence of pre-existing injury, disease or physical impairment? [ ] Yes [ ] No If Yes, please briefly describe.	
3 What are your findings?	4 What is your diagnosis?
5 Did the injury require hospitalization? [ ] Yes [ ] No Hospital name: Admission date: Discharge date:	6 Is additional treatment required? [ ] Yes [ ] No 7 Is medical evacuation overseas required? [ ] Yes, where .... [ ] No
8 Surgery performed if any (please describe) /date performed:	9 Other types of treatment applied: [ ] X-ray or imaging [ ] other __________________
10 Is there any likelihood of partial recovery within 1 to 3 years?	11 Dates of initial examination/ treatment /discharge From:..................................To: ....

<table>
<tr><td colspan="3">12 Recommendations for future care or treatment, if applicable</td></tr>
<tr><td>13. Name and signature of physician

Name

signature</td><td>14. Specialization</td><td>15. Date of this report</td></tr>
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