REASON FOR REPORT CIRCLE ONE INITIAL PROGRESS FINAL	M-1 PRACTITIONER'S REPORT STATE OF MAINE WORKERS' COMPENSATION BOARD Office of Medical/Rehabilitation Services	TYPE OF PRACTITIONER CIRCLE ONE MD (DO) DC LIST OTHER _____

EMPLOYEE

EMPLOYER NAME:	EMPLOYEE LAST NAME:	FIRST NAME:	M.I.:
EMPLOYER MAILING ADDRESS & PHONE #:	ADDRESS - NUMBER AND STREET:		
INSURER NAME:	CITY:	STATE: ZIP:	HOME PHONE:
INSURER MAILING ADDRESS:	DATE OF INJURY:	SSN:	
PATIENT'S COMPLAINTS:			

PRACTITIONER

INSTRUCTIONS:
Please fill out the fields above. Press the "PRINT" button when you are done and bring this with you to your next appointment.
Thank you.

PRINT THIS FORM **CLEAR FORM**

_____ JOHN PADAVANO, DO 55 BAXTER BLVD. PORTLAND, ME 04101

SIGNATURE OF PRACTITIONER — PRINT NAME AND ADDRESS

TELEPHONE #: _____ NARRATIVES ATTACHED? ☐ YES ☐ NO