



ASPS Member Surgeon



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Plastic & Reconstructive Surgery
Surgery of the Hand

**PATIENT INJURY REPORT
WORKERS COMPENSATION**
All sections must be completed

Name: _____ Date of Birth: _____

1. Employer at time of injury: _____

2. Job title: _____ shift scheduled to work _____ to _____

3. Describe your typical work duties: _____

4. Length of employment with this employer (in this job): _____

5. Date and time of injury: _____

6. Place injury occurred: _____

7. Current work status/last day worked: _____ Full/Light Duty? _____

8. Have you already had treatment for this injury? _____

9. In your own words, describe in detail how the injury occurred: _____

10. Current employer if no longer employed with employer stated above in question #1: _____
Date started: _____

11. Are you: _____ left-handed _____ right-handed 12. Is this a work-related injury? _____ Yes _____ No

SIGNATURE: _____ **DATE** _____

Fellow, American College of Surgeons
Diplomate of the American Board of Plastic Surgery
Certificate of Added Qualification in Hand Surgery