DVR-3C

CABINET FOR WORKFORCE DEVELOPMENT
DEPARTMENT OF VOCATIONAL REHABILITATION

SURGICAL REPORT

Patient Name:

Surgical Procedures:

Hospital Name:

Number of days to be hospitalized:

*****Assistant:

*****Anesthetist:

Report of Examination:

Vocational Prognosis:

SIGNED: _____ M.D.

Mail to:

Must have name of assistant and/or anesthetist. If that person is an employee of the hospital, the fee for the assistant and/or anesthetist can <u>not</u> be paid.