

Worker's Last Name	First Name	Claim Number
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Clinical Formulation and/or Diagnosis (if Worker only meets partial diagnostic criteria, indicate [sub-clinical]).

Primary Treatment Goals

1. _____

2. _____

3. _____

4. _____

5. _____

Treatment Plan (indicate anticipated number of sessions and session frequency).

Are there Psychological Barriers to a return to work? Yes No (If yes, please explain.)

Objective

Test Results (name of test, evidence of validity of results, summary interpretations).

Is worker fit to return to work with no restrictions? Yes No

I hereby certify the above is a correct statement of services personally rendered by myself.

Psychologist's Signature _____ Date _____

The WSCC may use this information for the administration of legislation under our authority, including the *Workers' Compensation Acts*, the *Safety Acts*, and/or the *Mine Health and Safety Acts*, and their associated *Regulations*, and to contact you in relation to the requirements under the relevant legislation.

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