IN THE COUNTY COURT OF _____ COUNTY, NEBRASKA
Choose the county

_____, Plaintiff,

vs.

_____, Defendant.

Case No. _____

HEALTH CARE PROVIDER REPORT IN LIEU OF TESTIMONY PURSUANT TO NEB. REV. STAT. § 25-2747(6)(a)(b)

Patient Name:

Type of Incident:

Date of Incident:

Please answer the following questions with information and opinions regarding the named patient.

___ Check here if you are attaching separate pages for any of your answers to the questions below. Be sure that the question to which your answer relates appears at the top of each additional page. *Number of additional pages:*_____

1. What degrees, licenses, and board certifications do you hold, if any, and what year was each of them attained? If the information is included in your curriculum vitae or resume, you may attach it to this report and answer this question by stating "See Attached."

2. What injuries, if any, did the patient sustain in the above-referenced incident?

3. What medical care has the patient received from you that was reasonably needed to treat the injuries the patient sustained in the incident? Include treatment provided by other care providers to the extent you are aware of such. Include medications prescribed, therapy recommended, surgery recommended, and any other treatments needed as a result of this injury.

4. Have there been or are there any restrictions or limitations placed on the patient or the patient's employment due to injuries sustained in the incident?

___ YES ___ NO

If YES, please describe them, including the actual or expected duration of the restrictions or limitations.

5. Has the patient reached maximum medical improvement from the injuries sustained in the incident? ___ YES ___ NO.

If YES, what is the date of the patient's maximum medical improvement? If NO, when do you expect the patient will reach maximum medical improvement?

6. If you have given the patient a permanent impairment rating for the injury, please state the rating.

7. Is there any additional care or are there any additional medications that are reasonably certain to be needed by and provided to the patient in the future as a result of the injuries sustained in the incident? ___ YES ___ NO

If YES, please describe the expected care or additional medications. Include in your description the expected frequency, duration, and, if known, reasonable cost.

8. To your knowledge, did the patient have any preexisting, symptomatic conditions that were aggravated by the injuries sustained in the incident?

___ YES ___ NO

If YES, please describe the preexisting conditions and the extent of their aggravation.

9. To your knowledge, did the patient have any preexisting, nondisabling, nonsymptomatic conditions that became symptomatic as a result of the incident?___ YES ___ NO

If YES, please describe the preexisting conditions and the extent of the symptoms.

10. To your knowledge, is there anything that the patient has done or failed to do that has aggravated the patient's condition or impaired the patient's recovery?___ YES ___ NO

If YES, please explain.

11. Have you reviewed or relied upon any medical records other than those generated by you or other providers in your office in forming your opinions to the answers to the questions above?
___YES ___ NO

If YES, please identify or attach the records that you have reviewed and relied upon in forming your answers.

12. Have you relied upon any other documents or information about the patient or the incident, other than the records indicated above? ___YES ___NO

If YES, please state what documents or information you relied upon, and the manner by which you received it.

Oath and Signature

I, [name of health care provider] , certify under penalty of perjury and pursuant to the laws of the State of Nebraska that the contents of this Report are true and correct and the opinions are stated with a reasonable degree of medical certainty.

Signature	Date:
Provider's Printed Name	Street Address/P.O. Box
	City/State/ZIP Code
Phone	Email Address

APPENDIX 2
Adopted December 8, 2021, effective January 1, 2022.

Attorney's Disclosure of Communications

List any oral, written, or electronic communications between you or anyone in your office and the above-named treating health care provider or anyone in the provider's office regarding [name of patient]_____.

For each such communication, identify the date of the communication and, if the communication was written or electronic, and attach copies of such communications.

Attorney's Oath and Signature

I, [name of attorney]_____, certify under penalty of perjury and pursuant to the laws of Nebraska that the contents of my Disclosure are true and correct.

_____	Date: _____
Signature	
_____	_____
Attorney's Printed Name	Street Address/P.O. Box
_____	_____
Bar Number and Firm Name (attorneys only)	City/State/ZIP Code
_____	_____
Phone	Email Address

APPENDIX 2

Adopted December 8, 2021, effective January 1, 2022.