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| **TO BE COMPLETED BY EMPLOYEE** |
| Employee Name: |  | Employee ID: |  |
| Department: |  | Supervisor: |  |
| Last Day Worked: |  | Proposed Return to Work Date: |  |
| I hereby grant permission to my attending physician and/or hospital to disclose the information or copies of records obtained during my examination or treatment for the injury mentioned below to my employer or their designated representative. |
| Employee Signature: |  |  | Date: |  |

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| **TO BE COMPLETED BY ATTENDING PHYSICIAN** |
| The patient was diagnosed with \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ and was seen and treated on \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. Given the nature of the injury/illness, |
| [ ]  The patient is currently fully incapacitated and will be reassessed on \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. |
| [ ]  The patient is fully capable of performing all assigned duties and may return to work without any restrictions or limitations as of \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_. |
| [ ]  The patient may return to work with the ability to perform duties, subject to the following restrictions, |

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| **WORK RESTRICTIONS** | **NONE** **0% of workday** | **OCCASIONALLY****1-33% of workday** | **FREQUENTLY****34-64% of workday** | **CONSISTENTLY****65-100% of workday** |
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| These restrictions will remain in place until \_\_\_\_ /\_\_\_\_ /\_\_\_\_\_\_\_ or until the patient is reassessed on \_\_\_\_ /\_\_\_\_ /\_\_\_\_\_\_\_. |
| Is the employee/patient able to work full-time hours?  | [ ]  Yes | [ ]  No |
| If the answer is NO, the maximum number of hours permitted per workday is \_\_\_\_\_\_\_ and the maximum number of hours permitted per week is \_\_\_\_\_\_\_. |
| I hereby certify that I have reviewed and fully comprehend the employee’s/ patient’s job description as outlined in the attached documentation. My professional findings and conclusions are based on a detailed medical evaluation of their physical and cognitive capabilities as they pertain to the essential duties and requirements of the position. |
| Name: |  |  |  |  |
| Phone No.: |  |  | Signature: |  |
| Address: |  |  | Date: |  |