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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: |  |