EMPLOYEE INSTRUCTIONS: Please provide this form to the treating physician for completion each time you see the physician for a work related injury. Once your capabilities are determined.

Last Name (M. Initial) Employee's First Name Social Security Number Date of Injury/Illness

Location Supervisor's Name Title

TO BE COMPLETED BY ATTENDING PHYSICIAN

ATTENDING PHYSICIAN: As a concerned employer, our goal is to ease the financial impact on employees and their families by providing modified duty placements for injured employees as soon as possible.

YOUR ASSISTANCE IS IMPERATIVE: Please complete the following information and we will attempt to develop a temporary assignment within the employee's physical abilities, if needed.

DIAGNOSIS/CONDITION: (Brief Explanation)_____

I saw and treated this patient on (Date)_____ and based on the above description of the patient's current medical situation:

(✓ CHECK ONE)

1. _____ He/She may return to work with no limitations on (Date)_____.

2. _____ He/She may return to work on (Date)_____ capable of working within the following:

A. In an 8 hour day employee may:

TOTAL HOURS PERFORMED DAILY

	Never	1-2	3-4	5-6	7-8
1. Lifting and/or Carrying up to 10 lbs.					
a) Lifting and/or Carrying 20 lbs. maximum & 10 lbs. frequently					
b) Lifting and/or Carrying 30 lbs. maximum & 20 lbs. frequently.					
c) Lifting and/or Carrying 50 lbs. maximum & 30 lbs. frequently.					
d) Lifting and/or Carrying 75 lbs. maximum & 50 lbs.. frequently.					
e) Lifting and/or Carrying 100 lbs. maximum & 75 lbs. frequently.					
f) Lifting and/or Carrying over 100 lbs.					
2. Reaching above shoulder height.					
a) Reaching at shoulder height (Forward)					
b) Reaching below shoulder height.					

TOTAL HOURS PERFORMED DAILY

	Never	1-2	3-4	5-6	7-8	Alternate
Stand						
Walk						
Sit						
Drive						

Alternate every _____ hours.

B. In an 8 hour day employee may:

	Never 0%	Occasional 1-33%	Frequently 34-66%	Constant 67-100%
Bend:				
Squat				
Climb				
Twist				

C. Repetitive use of hands: Please circle the hand (L = Left, R = Right)

	No Use	Occasional	Frequently	Constant
Grasping: Simple	L / R	L / R	L / R	L / R
Grasping: Moderate	L / R	L / R	L / R	L / R
Grasping: Forceful	L / R	L / R	L / R	L / R
Fine Manipulation	L / R	L / R	L / R	L / R
Push/Pull	L / R	L / R	L / R	L / R

These recommendations are in effect until patient is re-evaluated on (Date)_____.

_____ He/She is unable to return to work at this time.

COMMENTS:_____

AUTHORIZATION TO RELEASE INFORMATION

I Hereby Authorize My Attending Physician And/Or Hospital To Release Any Information Or Copies Thereof Acquired In The Course Of My Examination Or Treatment For The Injury Identified Above To My Employer Or His Representative.

Employee's Signature Date

Physician's Signature Date