

Medical Provider Form

Dear Medical Provider/Physician:

It is our understanding that you are currently or will be treating an employee of ours. It is our desire to have any of our disabled employees return to work as soon as medically feasible. Below, please find recommendations for return to work. If necessary, we ask that you give detailed medical restrictions for our employee to follow at work and at home. If you require greater detail concerning this employee's work responsibilities, please contact me directly. We would also be happy to answer any questions you might have. Your cooperation is highly valued and greatly appreciated.

Employee/Patient Name:		
Type of Injury or Illness:		Impairment:
Treatment and Comments:		
In your opinion, is the patient's condition work related? <input type="checkbox"/> Yes <input type="checkbox"/> No Please explain:		
<input type="checkbox"/> No Restrictions Needed <input type="checkbox"/> Restrictions (as noted below) in effect for _____ days <input type="checkbox"/> No Work		
Computer Usage: <input type="checkbox"/> No specific limits <input type="checkbox"/> Limited to _____ minutes/hour _____ hours/day	Standing and Sitting: Standing and sitting limited to _____ minutes/hour _____ hours/day	Bending: <input type="checkbox"/> No specific limits <input type="checkbox"/> Bending limited to _____ minutes/hour <input type="checkbox"/> Bending limited to _____ hours/day
Other Limitations: <input type="checkbox"/> No repetitive body motion (list body part) _____ or limited to _____ hours/day <input type="checkbox"/> No reaching above shoulders <input type="checkbox"/> No reaching below knees <input type="checkbox"/> Work hours limited to _____ hours/day _____ days/week <input type="checkbox"/> No climbing <input type="checkbox"/> Not to drive vehicles <input type="checkbox"/> Other (explain) _____ _____		
Follow-up appointment on _____ at _____ AM/PM with _____		

Medical Provider Signature

Print Name

Date