Physician Report / Employee Work Status

Physician: Please ensure that the employee receives a copy of this form and/or that it is faxed to employer.

EMPLOYEE NAME: _____

EMPLOYER NAME: _____FAX:_____

INSURANCE COMPANY: RTW, INC.

(AND ITS SUBSIDIARY INSURANCE COMPANIES) PHONE:_____ FAX: _____

DX:_____

WORK RELATED: ▫ NOT WORK RELATED: ▫ UNDETERMINED: ▫

RX:_____

PHYSICAL THERAPY AT:_____FREQUENCY_____DURATION:_____

▫ RETURN TO WORK REGULAR DUTY: ___/___/___(Date) MMI: YES ▫ NO ▫ ___/___/___ (Date) PPD ___%

▫ RETURN TO RESTRICTED WORK: ___/___/___ (Date) TO: ___/___/___ (Date)

EMPLOYEE CAN:	NEVER	OCCASIONAL	FREQUENT	CONTINUOUS
LIFT/CARRY: 0 to 10#	▫	▫	▫	▫
11 to 25#	▫	▫	▫	▫
26 to 35#	▫	▫	▫	▫
36 to 50#	▫	▫	▫	▫
51 to 75#	▫	▫	▫	▫
76 to 100#	▫	▫	▫	▫
REACH ABOVE SHOULDER	▫	▫	▫	▫
PUSH/PULL	▫	▫	▫	▫
SQUAT/KNEEL/STOOP	▫	▫	▫	▫
BENDING	▫	▫	▫	▫
CAN USE L/R HAND FOR: SIMPLE GRASPING	▫	▫	▫	▫
FIRM GRASPING	▫	▫	▫	▫
FINE MANIPULATION	▫	▫	▫	▫
TORQUING	▫	▫	▫	▫
WORK HOURS:	____FULL SHIFT	____PARTIAL SHIFT OR	____HRS/DAY (RESTRICTED)	
(NO. OF HOURS/DAY)	____SITTING	____STANDING	____WALKING	
MODIFICATIONS APPLY TO:	____WORK	____HOME	____LEISURE	

This patient's employer has a "return-to-work program" and is committed to providing work within any restrictions.

UNABLE TO WORK FROM: ___/___/___ (Date) TO: ___/___/___ (Date)

ADDITIONAL COMMENTS: _____

_____

RETURN TO CLINIC ON: ___/___/___ (Date)

REFERRAL TO: _____

PHYSICIAN'S SIGNATURE: _____ DATE: ___/___/___

(PRINTED NAME): _____ CLINIC: _____

ADDRESS: _____ CITY: _____

PHONE: _____ FAX: _____