ATTENDING PHYSICIAN'S REPORT

Patient's Name: ____
Employer: Wayne County Board of Education

Dear Doctor:

Please provide the following information related to this injury/illness. This will assist us in returning our employees to work. We have an extensive and comprehensive Return-to-Work program for employees who have been hurt on the job.

1. ____ Employee may return to normal duties at once.
2. ____ Employee may return to work with the following restrictions.

Hours/Day: ☐ No Restrictions ☐ 8 hours ☐ 6 hours ☐ 4 hours ☐ other __________

Days/Weeks: ☐ No Restrictions ☐ 5 days ☐ 4 days ☐ 3 days ☐ other _____________

Lifting: ☐ No Restrictions ☐ 40 lbs ☐ 30 lbs ☐ 20 lbs ☐ 10 lbs ☐ other_____

Movement: ☐ No Restrictions ☐ Limited Stooping ☐ Limited Bending
☐ Limited Overhead Reaching ☐ Other ______________________________

Other (please specify): ____

Length of restrictions: Resume regular duties after ___________ days, ***or***
Employee will be re-evaluated on (date) ________________

3. The employee is totally incapacitated at this time. Employee will be re-evaluated on: (date) _________________________________.

4. **Notice to physician and employee: This report must be returned to Patient's Employer within 24 hours of this office visit. (304) 272-5519 fax**

   I saw the patient on: (date) ____________ and have made the following diagnosis:

   DX: ____

   ____

5. Comments: ____

   ____

_______________________________________ _______________________________________
Physician's Signature Medical Facility Date