MEDICAL AUTHORIZATION AND ATTENDING PHYSICIAN'S REPORT

EMPLOYER, please complete:

Name Employee/Patient: Last:	First:
Date of Injury:	Soc.Sec. No:
Name of Employer/Company:	
Employer Signature:	Doctor to be Seen:

AUTHORIZED PHYSICIAN, please complete.

________________________________ has been treated today for

A post accident drug test (check one) Has _____ Has not _____ been completed.

In accordance with this patient's physical capability, check all that apply:

- ☐ May resume work immediately, no restrictions.
- ☐ May resume work immediately with the following restrictions:
- ☐ Sedentary work (sitting, occasional walking, standing, lifting less than 10 lbs).
- ☐ Light work (lifting less than 20 lbs).
- ☐ Medium work (lifting less than 50 lbs).
- ☐ Heavy work (lifting less than 100 lbs).
- ☐ He/she is released to work:
  - ☐ _______ hours per day
  - ☐ His/her normal shift
  - ☐ Repetitive Motion Restrictions:

FREQUENCY:	Left	Right
Occasional <33% of time		
Frequent 34-66% of time		
Constant 67-100% of time		

- ☐ He/she may return to work at full duty on (date)
- ☐ He/she has a return appointment on (date)

Please indicate any referrals that are required:

________________________________ ______________

Physician's Signature Date Physician's Name (type or print)