

Visit Date: _____

Name _____ **Social Security Number** _____

Company _____ **Job Title** _____

Nature of Injury

- New Injury
 Follow up
 Recurrence /aggravation of existing condition
 Fitness for Duty Evaluation
 Other

Diagnosis _____ **Date of Injury:** _____

Treatment _____ Non work-related

RECOMMENDATIONS FOR WORK	LIFTING LIMITED TO:	CARRYING LIMITED TO:	PUSHING/PULLING LIMITED TO:	POSITION LIMITATIONS
Regular Work	1-5 lbs.	1-5 lbs.	1-5 lbs.	No Exposure to Vibrating Tools
Dry Work	6-10 lbs.	6-10 lbs.	6-10 lbs.	No Repetitive Finger Motion
Floor Level Work	11-25 lbs.	11-25 lbs.	11-25 lbs.	No Repetitive Wrist Motion
Not to Drive Vehicles	26-40 lbs.	26-40 lbs.	26-40 lbs.	No Reaching Above Shoulders
No Work	41-75 lbs.	41-75 lbs.	41-75 lbs.	No Reaching Below Waist
	No Lifting	No Carrying	No Pushing/Pulling	No Bending
Decrease work requiring repeated stooping, crawling, kneeling, or cramped position to _____ min/hrs				
Decrease continuous walking or standing to _____ min/hrs				
Decrease continuous sitting to _____ min/hrs				

Other limitations / restrictions: _____

No use of: _____

Comments: _____

- Patient Disposition**
- Return to Supervisor: **NO** Restrictions
 - Return to Supervisor: **with** Restrictions (Above)
 - Send Home, Employee can work on: _____
 - Follow up with Occupational Health Services
 - Referred to: _____

Follow up appointment on: _____

The examinee has been advised regarding the results of this medical examination. Management has the final decision as to whether work restrictions can be accommodated.

Signature _____ **Date:** _____

White: OHS Chart

Yellow: Employee

Pink: Supervisor

Fax **white** copy to employer