

WORK DISABILITY SLIP

Date: _____

Time: _____ am/pm

Employee: _____

Employer/Location: _____

Date of Accident/Incident: _____

1. Diagnosis: _____

2. Treatment Plan:

3. Work Status:

_____ Employee may return to normal duties immediately

_____ Employee is totally incapacitated at this time

_____ Employee may return to Modified Duty with restrictions:

Hours/Day: _____ None 8 hrs _____ 4 hrs _____ Other: _____

Days/Week: _____ None 5 days _____ 3 days _____ Other: _____

Lifting: _____ None 50 lbs _____ 40 lbs _____ 30 lbs _____
20 lbs _____ 10 lbs _____ Other: _____Movement: _____ None _____ limited stooping/climbing
_____ limited bending/twisting
_____ limited overhead/reaching
_____ limited repetitive motion
_____ other: _____

4. Follow-up Doctor's Appointment: Date: _____ Time: _____ am/pm

5. Medical Causation: Work Related? _____ YES _____ NO

6. Comments: _____

Physician Signature: _____ Date: _____