

PHYSICIAN STATEMENT
(for non-work related injuries/illnesses)

Name of Patient: _____

Nature of injury/illness:

Treatment rendered by physician:

Can the above named individual return to regular duty immediately?

Yes: _____

No: _____ **Expected Date of Return:** _____

Can the above named individual return to modified duty immediately?

Yes: _____

No: _____ **Expected Date of Return:** _____

If yes, check all modified duty descriptions that the above named individual is able to perform and indicate work schedule(s). See reverse side of form.

Additional comments:

What treatments will be required to rehabilitate patient to full or modified duty?

How is rehabilitation progressing?

Date: _____

Signature of attending physician

Address: _____