PHYSICIAN'S AUTHORIZATION & RETURN TO WORK REPORT OR TEMPORARY MEDICAL RESTRICTIONS

RETURN FORM TO BOTH :

Name:_____ Sedgwick(Claims Administrator)

AND

at Email or Fax: _____ at Fax: (805) 389-4231

Instructions: Take this form (along with your job description) to the doctor listed below. Ask the doctor to fill out the bottom portion. Please return this form to your supervisor immediately after your appointment.

Medical Treatment is authorized with: _____

Employee Name: _____ Date of Injury: _____

Agency/Department: _____ Phone Number: _____

Address: _____

Supervisor's Signature: _____ Date: _____

PHYSICIAN'S REPORT

Dear Doctor: Our employees are our most valuable asset. Our goal is to provide modified work whenever possible. You can help us by providing us with the following information. If you have any questions, please feel free to call:_____ Sedgwick, our Workers' Compensation Administrator at (805)389-4200.

Description of accident/injury:

Basis for treatment: ☐ First Aid ☐ Industrial ☐ Non-Industrial ☐ Undetermined

Related to Prior Injury? ☐ Yes ☐ No

☐ May return to work with the following work restrictions: ☐ May return to regular work duties without restriction.

May not:

☐ Lift More than _____ lbs. ☐ Walk More than _____ hrs. ☐ Climb More than _____ hrs.

☐ Carry More than _____ lbs. ☐ Stand More than _____ hrs. ☐ Kneel More than _____ hrs.

☐ Push More than _____ lbs. ☐ Sit More than _____ hrs. ☐ Keyboard More than _____ min. per hr.

☐ Pull More than _____ lbs. ☐ Bend More than _____ hrs.

Limited use of: ☐ Hand(s) ☐ Arm(s) ☐ Leg(s) ☐ Right ☐ Left ☐ Both

Describe: _____

Other restrictions/comments: _____

These restrictions should be observed until: _____
Date

May not return to **any** work until: _____
Date

Diagnosis: _____

_____

Follow-up appointment required? ☐ Yes ☐ No _____
Date

Physician's Comments:

_____

_____

_____ _____ _____

Physician Name (Please Print) Physician Signature Date

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