NOTICE TO HEALTH CARE PROVIDER (FITNESS FOR WORK)

Company contact: _____ **Phone:** (____) _____-_____ **Fax:** (____) ____-_____

Company name is committed to doing everything we can to achieve a successful recovery and return to work for our injured employees. Our disability management program is designed to help them return to work safely and at the earliest opportunity, using appropriate modified work alternatives when needed.

Please complete the fitness for work section at the time of treatment and fax it to the above number, or have our employee return it. A reporting fee of $____ will be paid.

Authorization to release information (to be completed by injured employee)
Injury: _____ Injury date: _____

I hereby authorize my treating health care provider to release information related to my fitness for work.

Employee's Name: Print _____ Date: _____
Employee's Signature: _____

Fitness for work (to be completed by treating health care provider)
Examination date: _____ Injury: _____

Current capabilities: please make a selection below as they rate to the injury.

Sitting:	☐ Able	☐ Unable	☐ Limited to ____ hours per shift
Standing:	☐ Able	☐ Unable	☐ Limited to ____ hours per shift
Walking:	☐ Able	☐ Unable	☐ Limited to ____ hours per shift
Bending:	☐ Able	☐ Unable	☐ Limited
Twisting:	☐ Able	☐ Unable	☐ Limited
Kneeling/squatting:	☐ Able	☐ Unable	☐ Limited
Climbing:	☐ Able	☐ Unable	☐ Limited
Lifting	☐ Able	☐ Unable	☐ Limited to ____ hours per shift
Pushing/pulling:	☐ Able	☐ Unable	☐ Limited
Overhead reaching:	☐ Able	☐ Unable	☐ Limited
Driving:	☐ Able	☐ Unable	☐ Limited to ____ hours per shift

Number of hours patient is capable of working per day _____.
Reasons why the patient cannot work: ☐ hospitalized ☐ self-reported pain ☐ opioids/medication side effects

Additional comments/special considerations:
_____
_____

Estimated date fit for regular work: _____
Healthcare provider's name: Print name _____
Healthcare Provider's Signature: _____

Payment Address:
_____
_____