Attending Physicians Report
(please check appropriate boxes below)

Date of last treatment: ______________ Date of next follow-up appointment: __________

Diagnosis: ________________________________________________________________

☐ Patient may resume regular work duties as of this date:________________________

☐ Patient is unable to resume regular work duties:

  ☐ Temporarily.    ☐ Permanently.

☐ Patient is able to work on modified duty as of this date: ____________________

  ○ Patient is able to:

    • Bend:    ☐ Yes    ☐ No
    • Squat:   ☐ Yes    ☐ No
    • Climb:   ☐ Yes    ☐ No
    • Lift:    ☐ Yes    ☐ No

  ○ Patient can lift up to: ☐ 20 lbs. ☐ 50 lbs. ☐ over 50 lbs.

  ○ If hand/arm injury, patient can use hands for repetitive movements:

    • Simple grasping: ☐ Yes ☐ No
    • Pulling and pushing: ☐ Yes ☐ No
    • Repetitive wrist motion: ☐ Yes ☐ No

  ○ If foot injury, patient can use feet for repetitive movements:

    ☐ Yes    ☐ No

  ○ Further details of modified duty:

    ________________________________________________________________

Physician’s Name: __________________________ Telephone #: __________________

Physician’s Signature: ______________________ Date: __________________

4/10/09 revised