

**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: (859) 280-2880

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) 288-4300.

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