



WORKER'S INFORMATION

Worker's Surname		
First Name		
<input type="checkbox"/> Male	Telephone #	Date of Birth (d/m/y)
<input type="checkbox"/> Female		
Part of Body Injured		

HEALTH CARE PROVIDER'S INFORMATION

Health Care Provider's Name	
Health Care Provider's Address	
Health Care Provider's Telephone #	
Date of Visit (d/m/y)	Time of Visit
or Health Care Provider's Stamp	

PART A

Patient has no functional limitations

PART B

Patient has functional limitations and can return to work providing the following limitations can be appropriately accommodated:

- | | | |
|---|--|--|
| <input type="checkbox"/> No lifting | <input type="checkbox"/> Use of upper extremity* | <input type="checkbox"/> Sitting* |
| <input type="checkbox"/> No overhead lifting | <input type="checkbox"/> Bending, twisting or kneeling | <input type="checkbox"/> Limitations due to medications* |
| <input type="checkbox"/> Lifting as tolerated | <input type="checkbox"/> Climbing stairs/ladders | <input type="checkbox"/> Limitations due to environmental conditions |
| <input type="checkbox"/> Walking* | <input type="checkbox"/> Standing* | <input type="checkbox"/> Reduced hours* |
| <input type="checkbox"/> Other* _____ | | |

*Please provide further details on these limitations _____

Estimated duration of functional limitations (in days) _____

I have reviewed details of this report with patient Date of next visit (d/m/y) _____

I certify that this is a complete and accurate report. The fees charged are in accordance with the medical fee schedule and I have received no prior payment.

Health Care Provider's Signature _____ Date (d/m/y) _____