

**WORKERS' COMPENSATION
AUTHORIZATION FOR MEDICAL TREATMENT
PHYSICIANS / EMERGENCY TREATMENT
FIRST REPORT**

To facilitate payment of charges incurred in providing emergency medical services to a _____ Employee, upon completion of initial treatment, this form **must** be completed by medical provider and given to treated employee for return to _____.

It is the philosophy of _____ to maintain employees in a productive work situation, if feasible, after a work related injury. On a temporary basis we can place an employee in a modified work assignment, should the employee's injury prevent a full duty return to their original position. Therefore, _____ needs a statement on the physical capabilities of the employee to return to original job, or to a job with temporary modifications.

RE: _____ /_____/_____
(Name of Employee) (Date of Injury)

Authorized by: _____, Company: _____

Employee Signature for Release of information to above Employer _____

PHYSICIAN REPORT

The above patient was seen for:

Diagnosis / Problem Description

- () Minor medical care; no follow up needed.
- () Able to return to work immediately
- () Able to return to work on ____/____/____
- () Return for follow up care on ____/____/____

PHYSICAL LIMITATIONS (if any) UNTIL ____/____/____
Date

Employee Can Lift & Carry	Never	Occasional	Frequently	Continuous
Up to 10 lbs.				
15 - 35 lbs.				
35 - 50 lbs.				
50 - 75 lbs.				
75 - 100 lbs.				
<i>Reach above shoulder level</i>				
<i>Push / Pull</i>				
<i>Bend / Stoop / Crouch</i>				
<i>Squat / Kneel</i>				
<i>Sit / Stand</i>				
<i>Operate Motorized Equip.</i>				
<i>Repetitive Motion of Hand / Wrist / Elbow</i>				

Clinic or Medical Facility

PHYSICIAN - PA - RN SIGNATURE

DATE