PHYSICIAN'S REPORT
FOR
AUTHORIZED LEAVE OR WORK RESTRICTIONS

If applicable, the information you provide may be used to identify suitable tasks or assignments for this employee that are within her/his physical limitations based on the employee's job classification.

Employee's Name:_____

Date of Injury or Illness:_____ Date of Next Appointment:_____

Is the condition an on-the-job injury/illness? ___ Yes ___ No

Current return-to-work status (choose the most appropriate). This employee is:

( ) Able to return to regular work Date of return:_____

( ) Totally disabled and unable to perform any work Estimated date of return:_____

( ) Able to return to restricted work based on limitations listed below Date of return:_____

Total number of hours employee may work per day: _____ ***Projected time for restricted work:***_____

Work Restrictions (if applicable): Please list work restrictions you place on this employee **using the employee's attached job description**. No comment will mean that you deem that there are no work restrictions.

(*All City of Albany job descriptions are available at: www.cityofalbany.net/departments/human-resources/hiring*)

C – Continuous 100% to 67% F – Frequent 66% to 34% O – Occasional 33% to 1% NO – Not OK

ACTIVITY	C	F	O	NO	LIFT/CARRY	C	F	O	NO	ACTIVITY	RIGHT	LEFT
BEND					0-10 lbs.					PUSHING/PULLING	YES ( ) NO ( )	YES ( ) NO ( )
SQUAT					11-20 lbs.					GRASP/LIFT/CARRY	YES ( ) NO ( )	YES ( ) NO ( )
CLIMB					21-40 lbs.					FINE MANIPULATION	YES ( ) NO ( )	YES ( ) NO ( )
TWIST					41-60 lbs.					REACH ABOVE SHOULDER	YES ( ) NO ( )	YES ( ) NO ( )
CRAWL					Over 60 lbs.					USE FEET	YES ( ) NO ( )	YES ( ) NO ( )

Indicate the maximum hours per day each activity can be performed:

* Driving _____ hours Standing _____ hours Walking _____ hours Sitting _____ hours

[**driving* may include large trucks and heavy equipment, e.g., backhoes]

Medication: Is this employee currently prescribed medication for use during working hours that may affect alertness, ability to respond to an to the medication emergency, and/or ability to do her/his job (see attached job description): Yes ___ No ___ If yes, please list the nature of the reaction(s) to the medication:

_____

_____

Is the employee medically stationary? Yes ___ Date:_____ No ___ Anticipated Date:_____

Please list any restrictions you believe will be permanent and affect the ability of this employee to perform work:

_____

_____

_____

_____

Printed Name of Physician:_____ Telephone #:_____

Address:_____

Physician's Signature:_____ Date:_____

RETURN COMPLETED FORM TO: City of Albany, Human Resources Department
P.O. Box 490
Albany, OR 97321
FAX (541) 704-2324 | PHONE (541) 917-7500
Email: hr@cityofalbany.net