

OCCUPATIONAL HEALTH ASSESSMENT FORM

A

To be completed by employee

This form must be returned to your supervisor/principal within 24 hours of being away from work due to an injury or illness. Direct contact with your supervisor/principal must be maintained to facilitate participation in alternate or modified work.

First name: _____ Last name: _____

Employee phone number: _____ Department/School: _____

Date of injury: _____

Authorization to release information

I understand that alternate/modified duties are available in my workplace, and authorize my health-care provider _____ to release my functional (work) abilities to the division.
(print name and qualifications)

Employee signature: _____ Date: _____

B

To be completed by health-care provider

On the basis of my examination, this employee:

1

Is able to return to regular duties: ☐ yes ☐ no

2

Is able to return to duties, provided they do not perform the following activities:

- | | | | | |
|---|--|--------------------------------|---|--------------------------------|
| ☐ lift 0-10 lbs | ☐ push and pull | ☐ squat | ☐ stand | ☐ twist |
| ☐ lift 11-25 lbs | ☐ work with hands | ☐ climb | ☐ sit | ☐ drive |
| ☐ lift 26+ lbs | ☐ bend | ☐ reach | ☐ work above the shoulders | |

Comments:

Date: _____

Signature of health-care provider: _____

Health-care provider's phone number: _____

Date of next appointment: _____

Occupational Medicine Templates

Daniela Niemeyer



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