ATTENDING PHYSICIAN STATEMENT: WORKPLACE INJURY

Date: [Date]

Patient Information:
Name: [Patient Full Name]
Date of Birth: [DOB]
Claim Number (if known): [Claim #]

Employer Information:
Company Name: [Company Name]
Date of Injury: [Date of Incident]

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1. Medical Diagnosis:
[Insert ICD-10 code or description of injury/condition]

2. Treatment Plan:
[Describe medications, physical therapy, or surgical interventions]

3. Work Status (Check one):

- [ ] Patient may return to full duty with no restrictions.
- [ ] Patient may return to work with the restrictions listed below.
- [ ] Patient is totally disabled from work at this time.

4. Physical Restrictions (if applicable):
Lifting/Carrying: [e.g., Max 10 lbs]
Standing/Walking: [e.g., Max 2 hours per shift]
Other Limitations: [e.g., No overhead reaching, no repetitive bending]

5. Duration:
These restrictions are effective until: [Date of next evaluation or expected recovery]

6. Physician Certification:

Physician Name: [Printed Name]
Medical License Number: [License #]
Facility Name: [Clinic/Hospital Name]
Phone Number: [Phone Number]

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Physician Signature