

CITY OF TOLEDO
STATEMENT OF ATTENDING PHYSICIAN

(Division)
Patient _____ SS# _____ DOB _____
Last Name First Name MI

1. Is disability due to employment related cause? Yes No Unsure If yes, provide date of injury and history. _____

2. Treatment dates: _____ Re-Check _____
(Date of First Treatment) (Date of Latest Treatment) (Date of Re-Check)

3. Diagnosis _____

4. Description of medical service or surgical procedure _____

Where performed: Hospital Out-Patient Office _____ Still Confined

5. Prognosis _____

6. Did patient have any known pre-existing condition(s) which may have contributed to the diagnosis and/or disability? If yes, explain: _____

The City of Toledo will provide transitional work assignments for our employees. Please indicate medical restrictions.

Patient is able to return to work with no restrictions on _____ .

Patient is totally disabled from work from _____ thru _____ .

Patient may return to work with the following restrictions from _____ thru _____

- | | | |
|--|--|---|
| <input type="checkbox"/> No lifting | <input type="checkbox"/> No weight bearing | <input type="checkbox"/> Sedentary work. Lifting 101lbs. maximum |
| <input type="checkbox"/> No climbing | <input type="checkbox"/> No driving or operating machinery | <input type="checkbox"/> Light work. Lifting 20 lbs. maximum |
| <input type="checkbox"/> No bending | <input type="checkbox"/> No repetitive grasping | <input type="checkbox"/> Medium Work. Lifting 501bs. maximum |
| <input type="checkbox"/> No work overhead | <input type="checkbox"/> No twisting, pushing, pulling | <input type="checkbox"/> Heavy Work. Lifting 100 lbs. maximum |
| <input type="checkbox"/> No walking on uneven surfaces | <input type="checkbox"/> No repetitive motion | <input type="checkbox"/> One handed work only(left)(right) |
| <input type="checkbox"/> No vibrating tools | <input type="checkbox"/> Sitting ___hours | <input type="checkbox"/> Repetitive motion ___Hrs. per shift only |

OTHER INSTRUCTIONS AND/OR LIMITATIONS _____

All above restrictions are: Permanent Temporary

Physician's Signature Address and Telephone Date

Employee's Signature Division/Department Date

Please give original to employee to return to Department/Division and FAX copy of this to City of Toledo, Department of Human Resources at 245-1511.