Dear Doctor:

You are treating a valuable employee of ______________________________, which has designed an early return to work program to assist your patient in the transition to full duty employment, if needed.

This program has been developed to help the recovery and rehabilitation of the injured employee. **We ask that you complete the bottom of this form, plus the attached Physical Capabilities Worksheet, in order to fully understand the patient's limitations and restrictions.** We would like to work with you and your patient to find a transitional position, which will assure the employee's safety, as well as, assist in his/her recovery.

Below is the information for our Workers' Compensation Carrier:
New York State Insurance Fund
(*Fill in address & phone number of local branch*)

Please fill out below and return to: Email – Claims@keevily.com / Fax 914-381-1134

Patient's Name: ________________________ Social Security #: _____________________

Date of Injury: _________________________ Date of Exam: _______________________

Based upon this examination (history, physical evaluation and tests, if any), it is the opinion of this physician:

{ } May resume full duty immediately

{ } May resume work immediately, with limitation indicated on attached Physical Capability Worksheet and has what percentage (0-100%) of the temporary impairment?
_______________ (0-100%)
Please make sure to complete the Physical Capability Worksheet

{ } Projected full duty return to work: ____________________

{ } Should return for treatment on: ______________________

{ } Next office visit: ___________________________________

Based on the patient's history, where and how did the injury/illness happen:____

____

____

__________________________________ _________________
Signature of examining physician Date

Physical Capabilities Worksheet

You are treating a valuable employee and we would like to assist in this patient recovery back to full health. We are able to accommodating many restrictions you find necessary to ensure the full recovery of this patient and assist in the transition to full duty employment.

We ask that you complete this form after your examination and outline all restrictions, if any, you have assigned to this patient. Please include modified hours, duties and any other information pertinent to this employee's healthy recovery.

Employee: _____________________________________ Employer: ____________________________________

Date of Injury: __________________________________ Claim Number: _________________________________

Mark the appropriate box for each of the following activities to indicate the extent to which the employee can perform:

Activity	N	S	O	C	Activity	N	S	O	C
Lifting/Carrying:					Bend				
10 Lbs. or less					Squat				
11 – 20 Lbs.					Kneel				
21- 40 Lbs.					Twist/Turn				
40- 60 Lbs.					Climb				
61 – 100 Lbs.					Crawl				
100 + Lbs.					Stand				
Comments:					Reach Above Shoulder				
Pushing/Pulling	N	S	O	C	Walk				
12 Lbs. or less					Sit				
13-25 Lbs.					Type/Keyboard				
26-40 Lbs.									
41-60 Lbs.					**Drive:**				
61-100 Lbs.					Automatic				
100+ Lbs.					Standard				
Comments					Comments:				
Please Comment on Degree of Disability or Additional Restrictions :									

Key:
N = Never
S = Sometimes; 1 – 33% of time
O = Occasional; 34-66% of time
C = Constant; 67-100% of time

Physician Name ___________________________________

Date ____

Telephone ____

Physician's Signature _______________________________

Please fax form to:

Fax # 914-381-1134