# Work Evaluation Form

## Section 1

| Employee/Patient Name (First, MI, Last): | | Employee Date of Birth: |
|---|---|---|
| Employer: | Injury Date: | Date of Exam: |

## Section 2

| Injury Type (check all that apply):<br>☐ New Injury ☐ No Injury Found<br>☐ Aggravation/Recurrence of Existing | Body Parts Injured: | Diagnosis: |
|---|---|---|
| Treatment: | Medications Prescribed: | Further Treatment Needed?<br>☐ Yes ☐ No<br>☐ As Needed |

## Section 3

| Is Patient Permanent & Stationary?<br>☐ Yes ☐ No<br><br>Permanent Disability Expected?<br>☐ Yes ☐ No | Work Status:<br>☐ Return to full duty with no restrictions on________(date)<br>☐ Return to work with restrictions on ______________(date) for _________(days)<br>☐ Return to full duty with no restrictions on________(date) |
|---|---|
| Physical Restrictions (Please indicate restrictions by entering limitation information): | Next Appointments/Comments: |

## Section 4

**Medical Provider Signature**

The contents of this report are true and correct and to the best of my knowledge.

_______________________________ Provider Name

_______________________________ Provider Signature

_______________ Date

_______________________________ Clinic Name

(        )_______________ Clinic/Provider Phone Number