MEDICAL PROVIDER FORM

Dear Medical Provider/Physician:

It is our understanding that you are currently or will be treating an employee of ours. It is our desire to have any of our disabled employees return to work as soon as medically feasible. Below, please find recommendations for return to work. If necessary, we ask that you give detailed medical restrictions for our employee to follow at work and at home. If you require greater detail concerning this employee's work responsibilities, please contact me directly. We would also be happy to answer any questions you might have. Your cooperation is highly valued and greatly appreciated.

Employee/Patient Name:

Type of Injury or Illness: Impairment:

Treatment and Comments:

In your opinion, is the patient's condition work related? ☐ Yes ☐ No Please explain:

☐ No Restrictions Needed ☐ Restrictions *(as noted below)* in effect for _____ days ☐ No Work

Computer Usage:

☐ No specific limits
☐ Limited to

_____ minutes/hour

_____ hours/day

Standing and Sitting:

Standing and sitting limited to

_____ minutes/hour

_____ hours/day

Bending:

☐ No specific limits
☐ Bending limited to ____ minutes/hour
☐ Bending limited to _____ hours/day

Other Limitations:

☐ No repetitive body motion *(list body part)* _____ or limited to _____ hours/day
☐ No reaching above shoulders ☐ No reaching below knees ☐ Work hours limited to _____ hours/day _____ days/week
☐ No climbing ☐ Not to drive vehicles ☐ Other *(explain)* _____

Estimated date when employee will be able to return to work:

_____ _____ _____
Medical Provider Signature Print Name Date

Please return completed form to: Michael Thayer, Employment Manager, Human Resources, Hamilton College
Telephone: (315) 859-4688 Fax: (315) 859-4047