

In Your Medical Opinion:

1. Has the Patient reached Maximum Medical Improvement: Yes No
If yes, at what date: / /

2. Is the Patient now able to perform the Regular and Continuous Duties of Employment as outlined in the provided Job Description: Yes No

*If no, do you feel the patient will be able to perform those duties in the future:
 Yes No

3. Is the patient, at present time, incapacitated from performing any duties for gainful employment: Yes No

*If yes, do you feel the patient will be able to perform any duties for gainful employment in the future: Yes No

4. If the Patient is capable of performing any "light duty" functions, please explain what employment Restrictions should be imposed: _____

Did the patient's injury, disease or disability occur:

On-the-Job or Off-the-Job

Please attach any additional comments or Explanations

Print Name of Physician _____

Specialty _____

Address _____

Telephone _____ Fax _____

Signature _____ **Date** _____