WORKERS' COMPENSATION
ATTENDING PHYSICIAN'S STATEMENT

This form is to be completed by the attending physician for each appointment.

Please Complete and Fax or Email to:

Risk Management Office | Fax # (301) 952-6027 | workers.compensation@pgcps.org

Send Medical Payments to:
Sedgwick
P.O. Box 14491
Lexington, KY 40512-4491
Main: 1855-653-7470
Fax: 1859-264-4060

TO BE COMPLETED BY THE EMPLOYEE

NOTE: Disability Leave cannot be processed if this form is not received along with the Worker's Compensation Verification of Employee's Lost (VLT) Time form by the Risk Management Office.

Name of Injured Employee: _____Employee (EIN):_____

Injured Employee Occupation: _____ Employee Phone #: (_____)_____-_____

School/Dept.: _____ Date of Injury: _____/_____/_____

Employee's Description of Accident/Injury:

_____

_____

Are you currently in the Transition-to-Work (TTW) Program? ☐ Yes ☐ No ☐ Not in the program but applied

TO BE COMPLETED BY PHYSICIAN – PART I

Date of this Examination: _____/_____/_____ (MM/DD/YY)

This is a (*please check one box*): ☐ First Report ☐ Progress Report ☐ Final Report

DIAGNOSIS AND CONCURRENT CONDITIONS: (If fracture or dislocation, describe nature and location. If sickness/illness describe the nature).

_____

_____

Is further treatment needed? ☐ No ☐ Yes If Yes, for how long? _____ ☐ Days ☐ Weeks ☐ Months

NEXT APPOINTMENT DATE:

Patient has a return appointment on (date):

Light Duty maybe available to all eligible employees who are released back to work with restrictions.

RETURN TO WORK STATUS

The patient is (**CHECK ONE**):

☐ **UNABLE** to return to work in any capacity. **Effective Date(s): FROM: ____/____/____ TO: ___/____/____**

If patient is not hospitalized, explain why he/she is unable to work in *any* capacity, including sedentary, part-time with restrictions:

_____

_____

(Proceed to sign and provide physician's stamp on page 2)

☐ **ABLE TO RETURN TO FULL DUTY/NO RESTRICTIONS** on (date): _____/_____/_____

(Proceed to sign and provide physician's stamp at bottom of page)

☐ **ABLE TO RETURN WITH RESTRICTIONS** *(Complete Part II)*

Name of Injured Employee: _____

TO BE COMPLETED BY PHYSICIAN – PART II

RESTRICTIONS:

Effective Date(s): FROM: _____/_____/_____ **TO:** _____/_____/_____ **(REQUIRED)**

In accordance with this patient's physical capability, check all that apply:

☐ May resume work immediately, with the following restrictions:

- ☐ Sedentary work (sitting, occasional walking, standing, lifting less than 10 pounds)
- ☐ Light work (lifting less than 20 pounds)
- ☐ Medium work (lifting less than 50 pounds)
- ☐ Limited hours: _____hours per day
- ☐ Limited days: _____days per week
- ☐ Limited walking: ____ hours per day
- ☐ Limited standing: ____ hours per day
- ☐ Limited sitting: ____ hours per day
- ☐ ___ Limited *or* ____ No bending
- ☐ ___ Limited *or* ___ No pulling/pushing ___ lbs.
- ☐ Other:_____

  _____
- ☐ Repetitive motion restrictions (specific to hand/arm injuries):

FREQUENCY	No Use	Occasional	Frequent	Constant
LEFT	☐	☐	☐	☐
RIGHT	☐	☐	☐	☐

I CERTIFY THAT THE ABOVE NAMED EMPLOYEE IS/WAS UNDER MY PROFESSIONAL CARE AND IS/WAS DISABLED FOR THE TIME PERIOD SPECIFIED ABOVE.

Name of Physician: _____

Signature of Physician: _____

Physician Address: _____

_____

Physician Phone: (_____) _____-_____ **Date Signed:** _____ /_____/_____

PHYSICIAN's STAMP

PRINCE GEORGE'S COUNTY PUBLIC SCHOOLS – Risk Management & Workers' Compensation Office
14201 SCHOOL LANE, TEMP 06-470, UPPER MARLBORO, MD 20772 **Website**: www.PGCPS.org