

If still impaired and unable to work, give approximate date when the patient should be able to return to work:
Or if indefinite, the estimated number of additional weeks before return:
How long was or will the patient be impaired and partially unable to work (able to work part-time at own occupation):
From: _____ To: _____
How does present condition affect the patient's ability to work:

Signature of Physician _____ Date Signed _____

Physician's Name/Specialty/License Number _____ Phone# _____

_____ Fax# _____

RETURN THIS COMPLETED FORM TO THE PATIENT.