# Attachment #2

ANNA JAQUES HOSPITAL

OCCUPATIONAL HEALTH SERVICES
(978) 834-8190

DATE: _____

EMPLOYEE NAME: _____

ADDRESS: _____

_____

TEL. NO.: _____

DATE OF BIRTH _____

USUAL WORK ASSIGNMENT: _____

Reason for Visit: _____

_____

_____

_____

EMPLOYER

NAME: _____

ADDRESS: _____

_____

TEL. NO.: _____

PLANT CONTACT PERSON: _____

Can MODIFIED WORK ASSIGNMENT be provided for this employee? YES ☐ NO ☐

Authorized Signature _____

CONSENT TO RELEASE INFORMATION: I, _____, agree that my employer and Anna Jaques Hospital or the provider whose name is signed below may communicate such information as is necessary regarding my current work assignment and this medical evaluation.

Employee Signature: _____ Date: _____

(ALL INFORMATION ABOVE LINE TO BE COMPLETED BY EMPLOYER)

Results of Evaluation: _____

_____

_____



WORK RECOMMENDATIONS:

☐ NO LIMITATIONS - may return to full activity

☐ PARTIAL DISABILITY - limited job assignment by employer that will avoid:

- ☐ lifting over 25/50 lbs.
- ☐ repetitive squatting, kneeling
- ☐ repetitive stooping, twisting
- ☐ prolonged standing, walking
- ☐ soiling of sutured area
- ☐ must be able to wear gloves
- ☐ repetitive motion of upper extremity
  - ☐ right ☐ left
- ☐ work involving heights
- ☐ work around skin irritants
- ☐ work involving dust/fumes/airborne particles
- ☐ work requiring depth perception (i.e., operating machinery, heavy equipment or driving)
- ☐ Other: _____

☐ COMPLETE DISABILITY

Above recommendations are effective for approximately _____ days.

NOTE: Emergency Department Physician cannot certify disability for longer than seven (7) days.

If symptoms entirely resolve or no other medical complications, may return to work on _____.

If unable to return to work after this time, follow-up with _____.

Signed: _____

Provider Signature

OHS-602
(Approved Med. Rec. Comm. 8/15/86) Distribution:
White - Emergency Dept./OHS Yellow - Client Company Pink - OHS Goldenrod - Business Office