Authorization To Render Medical Care and Physician's First Aid/Return To Work Evaluation If you have no designated doctor, you are required to report to Prestige Urgent Care, 3689 Eureka Way, Rdg, 530-244-4577

Doctor_____ Phone _____ Fax _____

Address _____

AUTHORIZATION TO RENDER MEDICAL CARE

Please render medical care to the following employee in accordance with worker's compensation laws.

EMPLOYEE_____ EMPLOYER _____

DISTRICT ADDRESS 1644 Magnolia Ave. . PHONE 530-225-0205 FAX 530-245-7826

AUTHORIZATION DATE_____ ☐ INITIAL VISIT **OR** ☐ FOLLOW-UP VISIT

DATE/INJURY_____TIME/INJURY_____ ☐ AM ☐ PM NATURE OF INJURY_____

AUTHORIZED BY:_____ _____ _____ _____

PRINT OR TYPE SIGNATURE TITLE DATE

MEDICAL EVALUATION OF EMPLOYEE'S ABILITY TO RETURN TO WORK

We believe efforts to return employees to work enhances the psychological and physical recovery process. Please complete this form to assist our school district in providing a safe return to work for our employee.

A. Can this patient return to work? ☐ Yes ☐ No

B. Can this patient perform all the essential functions of the job and return to work without restrictions? ☐ Yes ☐ No

C. Can this patient return to work with restrictions? ☐ Yes, Please complete remainder of this form.

D. Circle number of hours this patient is physically able to perform the following function's in an 8-hour work day:

1. Sit	0	½	1	2	3	4	5	6	7	8
2. Stand	0	½	1	2	3	4	5	6	7	8
3. Walk	0	½	1	2	3	4	5	6	7	8
4. Drive	0	½	1	2	3	4	5	6	7	8

E. Please check the appropriate box or enter the number of times per day or per hour this patient can safely perform the following function's in an 8-hour work day:

CATEGORY	NOT AT ALL	NO.OF TIMES/DAY	NO. OF TIME/HR.	CONTINUOUSLY
1. Bend/stoop/kneel	☐	☐	☐	☐
2. Reach	☐	☐	☐	☐
3. Twist	☐	☐	☐	☐
4. Climb stairs	☐	☐	☐	☐
5. Repetitious use of_____	☐	☐	☐	☐
6. Push/Pull	☐	☐	☐	☐
7. Climb ladders	☐	☐	☐	☐

D. Please check the appropriate box or enter the number of times per day or per hour this patient can safely lift, push, pull or carry the following weight in an 8-hour day.

CATEGORY	NOT AT ALL	NO.OF TIMES/DAY	NO.OF TIMES/HR.	CONTINUOUSLY
1. Up to 5 pounds	☐	☐	☐	☐
2. 6-15 pounds	☐	☐	☐	☐
3. 16-25 pounds	☐	☐	☐	☐
4. 26-50 pounds	☐	☐	☐	☐

E. Other work restrictions and/or limitations:_____

F. These restrictions are in effect until_____ or until patient is reevaluated on_____

Date Date

Person to contact at physician's office regarding above-noted restrictions: _____ Phone_____

PHYSICIAN NAME (please print) _____

PHYSICIAN'S SIGNATURE_____DATE_____

☐Please check if this is a First Aid.

☐Return this completed form to our employee.

☐Please also fax this form to Shasta County Office of Education Attention:HR at 530-245-7826