CITY OF TOLEDO
STATEMENT OF ATTENDING PHYSICIAN

Please give original to employee and FAX a copy of this to the City at 419.245.1501.

Patient _____ SS# _____ DOB _____
Last Name First Name MI

1. Is illness/injury employment related? Yes □ No□ Describe: _____

2. Describe illness/injury and history: _____

_____

3. Treatment dates: _____
(Latest Treatments)

4. Diagnosis: _____

_____

5. Description of medical service or procedure _____

_____

Performed: Hospital □, Office □, Other □ - describe _____

6. Prognosis _____

7. Describe any known, contributing, pre-existing condition(s) if any: _____

_____

8. Patient Incapacity, if applicable:
□ Patient is able to return to work with no restrictions on: _____
□ Patient is physically/psychologically unable to work from: _____ to _____
□ Patient may return to work with the below restrictions from: _____ to _____

The City of Toledo may be able to provide transitional work assignments for our employees.

___No lifting	___No weight bearing	___Sedentary work. Lifting 101bs. Max.
___No climbing	___No driving or operating machinery	___Light work. Lifting 20 lbs. Max.
___No bending	___No repetitive grasping	___Medium Work. Lifting 501bs. Max.
___No work overhead	___No twisting, pushing, pulling	___Heavy Work. Lifting 100 lbs. Max.
___Sitting ___hours	___No walking on uneven surfaces	___One handed work only(left)(right)
___No vibrating tools	___No repetitive motion	___Repetitive motion ___Hrs. per shift

Other instructions and/or limitations: _____

_____

_____

(Physician's Signature) (Physician – Print) (Phone) (Date)

_____

(Physician Address) (Employee Signature)